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MT LEGISLATIVE HISTORY

Chapter 161 1989

Bill (H) 33 S _____ Original bill & hist. ✓C

H. Committee on Human Services & Aging

Hearing Date(s) Jan 04 ✓C
Jan 09 ✓C
_____ ___C
_____ ___C

Date Out Jan 09 ✓C

S. Committee on Public Health, Welfare & Safety

Hearing Date(s) Mar 01 ✓C
_____ ___C
_____ ___C
_____ ___C

Date Out Mar 02 ✓C

Did this bill originate in an interim committee? ___Yes ___No

Committee _____ Report _____

HOUSE BILL NO. 33

INTRODUCED BY PAVLOVICH

IN THE HOUSE

DECEMBER 30, 1988	INTRODUCED AND REFERRED TO COMMITTEE ON HUMAN SERVICES & AGING.
JANUARY 2, 1989	FIRST READING.
JANUARY 10, 1989	COMMITTEE RECOMMEND BILL DO PASS AS AMENDED. REPORT ADOPTED.
JANUARY 11, 1989	PRINTING REPORT.
JANUARY 12, 1989	SECOND READING, DO PASS AS AMENDED.
	STATEMENT OF INTENT ADOPTED.
JANUARY 13, 1989	ENGROSSING REPORT.
JANUARY 14, 1989	THIRD READING, PASSED. AYES, 91; NOES, 4.
	TRANSMITTED TO SENATE.

IN THE SENATE

JANUARY 16, 1989	INTRODUCED AND REFERRED TO COMMITTEE ON PUBLIC HEALTH, WELFARE & SAFETY.
	FIRST READING.
MARCH 2, 1989	COMMITTEE RECOMMEND BILL BE CONCURRED IN AS AMENDED. REPORT ADOPTED.
MARCH 3, 1989	SECOND READING, CONCURRED IN.
MARCH 6, 1989	THIRD READING, CONCURRED IN. AYES, 47; NOES, 3.
	RETURNED TO HOUSE.

IN THE HOUSE

MARCH 8, 1989	RECEIVED FROM SENATE.
	SECOND READING, AMENDMENTS CONCURRED IN.
MARCH 9, 1989	THIRD READING, AMENDMENTS CONCURRED IN.
	SENT TO ENROLLING.
	REPORTED CORRECTLY ENROLLED.

HOUSE BILL NO. 33

INTRODUCED BY PAVLOVICH

A BILL FOR AN ACT ENTITLED: "AN ACT REQUIRING A WORKERS' COMPENSATION IMPAIRMENT EVALUATOR TO BE A CHIROPRACTOR IF THE CLAIMANT'S TREATING PHYSICIAN IS A CHIROPRACTOR; AND AMENDING SECTIONS 37-12-201 AND 39-71-711, MCA."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

Section 1. Section 37-12-201, MCA, is amended to read:

"**37-12-201. Organization of board -- meetings -- powers and duties.** (1) The board shall elect annually a president, vice-president, and secretary-treasurer from its membership.

(2) The board shall hold a regular meeting each year at Helena and shall hold special meetings at times and places as a majority of the board designates. A majority of the board constitutes a quorum.

(3) The board shall:

(a) administer oaths, take affidavits, summon witnesses, and take testimony as to matters coming within the scope of the board;

(b) adopt a seal which shall be affixed to licenses issued;

(c) make a schedule of minimum educational requirements, which are without prejudice, partiality, or discrimination, as to the different schools of chiropractic;

(d) adopt rules necessary for the implementation, administration, continuation, and enforcement of this chapter. The rules must address but are not limited to license applications, form and display of license, license examination format, criteria for and grading of examinations, and disciplinary standards for licensees;

(e) investigate complaints;

(f) make determinations of the qualifications of applicants under this chapter;

(g) administer the examination for licensure under this chapter;

(h) collect fees and charges prescribed in this chapter; and

(i) issue, suspend, or revoke licenses under the conditions prescribed in this chapter; and

(j) certify that a chiropractor who meets the standards that the board by rule adopts is a qualified evaluator for purposes of 39-71-711.

(4) The department shall keep a record of the proceedings of the board, which shall at all times be open to public inspection."

Section 2. Section 39-71-711, MCA, is amended to read:

"**39-71-711. Impairment evaluation -- ratings.** (1) An

LC 0115/01

INTRODUCED BILL

HB 33

impairment rating:

(a) is a purely medical determination and must be determined by an impairment evaluator after a claimant has reached maximum healing;

(b) must be based on the current edition of the Guides to Evaluation of Permanent Impairment published by the American Medical Association; and

(c) must be expressed as a percentage of the whole person.

(2) A claimant or insurer, or both, may obtain an impairment rating from a physician of the party's choice. If the claimant and insurer cannot agree upon the rating, the procedure in subsection (3) must be followed.

(3) (a) Upon request of the claimant or insurer, the division shall direct the claimant to an evaluator for a rating. The evaluator shall:

(i) evaluate the claimant to determine the degree of impairment, if any, that exists due to the injury; and

(ii) submit a report to the division, the claimant, and the insurer.

(b) Unless the following procedure is followed, the insurer shall begin paying the impairment award, if any, within 30 days of the evaluator's mailing of the report:

(i) Either the claimant or the insurer, within 15 days after the date of mailing of the report by the first

evaluator, may request that the claimant be evaluated by a second evaluator. If a second evaluation is requested, the division shall direct the claimant to a second evaluator, who shall determine the degree of impairment, if any, that exists due to the injury.

(ii) The reports of both examinations must be submitted to a third evaluator, who may also examine the claimant or seek other consultation. The three evaluators shall consult with one another, and then the third evaluator shall submit a final report to the division, the claimant, and the insurer. The final report must state the degree of impairment, if any, that exists due to the injury.

(iii) Unless either party disputes the rating in the final report as provided in subsection (6), the insurer shall begin paying the impairment award, if any, within 45 days of the date of mailing of the report by the third evaluator.

(4) The division shall appoint impairment evaluators to render ratings under subsection (1). The division shall adopt rules that set forth the qualifications of evaluators and the locations of examinations. An evaluator must be a physician licensed under Title 37, chapter 3, except that if the claimant's treating physician is a chiropractic physician, the evaluator must be a chiropractic physician licensed under Title 37, chapter 12, and must be certified

as an evaluator under that chapter. The division may seek nominations from the board of medical examiners for evaluators licensed under Title 37, chapter 3, and from the board of chiropractors for evaluators licensed under Title 37, chapter 12.

(5) The cost of impairment evaluations is assessed to the insurer, except that the cost of an evaluation under subsection (3)(b)(i) or (3)(b)(ii) is assessed to the requesting party.

(6) A party may dispute a final impairment rating rendered under subsection (3)(b)(ii) by filing a petition with the workers' compensation court within 15 days of the evaluator's mailing of the report. Disputes over impairment ratings are not subject to 39-71-605 or to mandatory mediation.

(7) An impairment rating rendered under subsection (3) is presumed correct. This presumption is rebuttable."

Section 3. Extension of authority. Any existing authority to make rules on the subject of the provisions of [this act] is extended to the provisions of [this act].

-End-

DATE 3/1/89

COMMITTEE ON Public Health

VISITORS' REGISTER

NAME	REPRESENTING	BILL #	Check One: Support	Opp
Rep Angela Russell	HD 99	305	X	
Sen Linda, ICW Spec.	DFS	305	X	
George Wood	Mt. Self Insurers Assn			HB 33
Bill Potts	MT. Dept. of Health	484	X	
M.H. Pardis, D.C.	Mont Chiro. Assn	HB 33	X	
Lee Hudson, DC, DABCO	Mont. Chiropractic Assn	HB 33	X	
Norm Grosfield	self	HB33	X	
Bonnie Lyon	MT Chiropractic Assn	HB 33	X	
GARY BLOM	MT. Chiro Assoc	HB33	X	
[illegible]	Mt. Nurses Assoc	HB 33	X	
Rep Ed Kennedy	Butte HD #70	HB33	X	
Chuck Kaufman	MEIC	HB 484	X	
[illegible]	MHC	HB 33	X	
[illegible]	Rural Health Assoc.	305	✓	

(Please leave prepared statement with Secretary)

ROLL CALL VOTE

SENATE COMMITTEE PUBLIC HEALTH

Date 3/1/89 Bill No. HB 33 Time 2/15

NAME	YES	NO
SEN. TOM HAGER	X	
SEN. TOM RASMUSSEN	X	
SEN. LYNCH	X	
SEN. HIMSL	X	
SEN. NORMAN	X	
SEN. McLANE	X	
SEN. PIPINICH	absent	

Dorothy Quinn
Secretary

Sen. Tom Hager
Chairman

Motion: Sen Lynch moved that HB 33 as of the amendment be passed & Senator in favor

6 - 0

1989

ROLL CALL VOTE

SENATE COMMITTEE PUBLIC HEALTH

Date 3/1/89 Bill No. HB 33 Time 3:20

NAME	YES	NO
SEN. TOM HAGER	X	
SEN. TOM RASMUSSEN	X	
SEN. LYNCH	X	
SEN. HIMSL	X	
SEN. NORMAN	X	
SEN. McLANE	X	
SEN. PIPINICH	absent	

Dorothy Quinn
Secretary

Sen. Tom Hager
Chairman

Motion: Sen. Lynch moved that HB 33 be committed as amended 6-0

1989

Form CS-32
Rev. 1985

STATUS SHEET

____ LEGISLATIVE SESSION

HUMAN SERVICES AND AGING COMMITTEE

BILL NUMBER	ENTERED COM. DATE	DATE CONSIDERED	OUT OF COM.	DO PASS DATE	DO NOT PASS DATE	DO PASS AS AMENDED DATE	DO NOT PASS AS AMENDED DATE	BE CONCURRED IN DATE	BE NOT CONCURRED IN DATE	BE CONCURRED IN AMENDED DATE	BE NOT CONCURRED IN AS AMENDED DATE
HB33	1-4-89	1-4-89	1-9-89			1-9-89					
HB37	1-4-89	1-4-89	1-6-89	1-6-89							
HB66	1-4-89	2-1-89	2-10-89			2-10-89					
HB73	1-6-89	1-9-89	1-13-89			1-13-89					
HB80	1-6-89	1-9-89	1-9-89	1-9-89							
HB86	1-6-89	1-11-89	TABLE 1-20-89								
HB87	1-6-89	1-11-89	1-19-89			1-19-89					
HB102	1-10-89	1-13-89	1-13-89	1-13-89							
HB113	1-12-89	1-13-89	1-13-89	1-13-89							
HB115	1-12-89	1-16-89	1-17-89			1-17-89					
HB116	1-12-89	1-18-89	1-19-89	1-19-89							
HB192	1-16-89	1-20-89	1-20-89			1-20-89					
HB200	1-17-89	1-18-89	2-10-89			2-10-89					
HB211	1-17-89	1-20-89	1-26-89			1-26-89					

e a separate sheet for Senate Bills, House Bills, and Resolutions.

3/1/89 #2

All courses within the curriculum must be completed at Palmer College of Chiropractic-West unless the student has been granted advanced standing credit for courses completed elsewhere.

Courses are identified by discipline, title, course number, hours devoted to lecture and laboratory, and total hours.

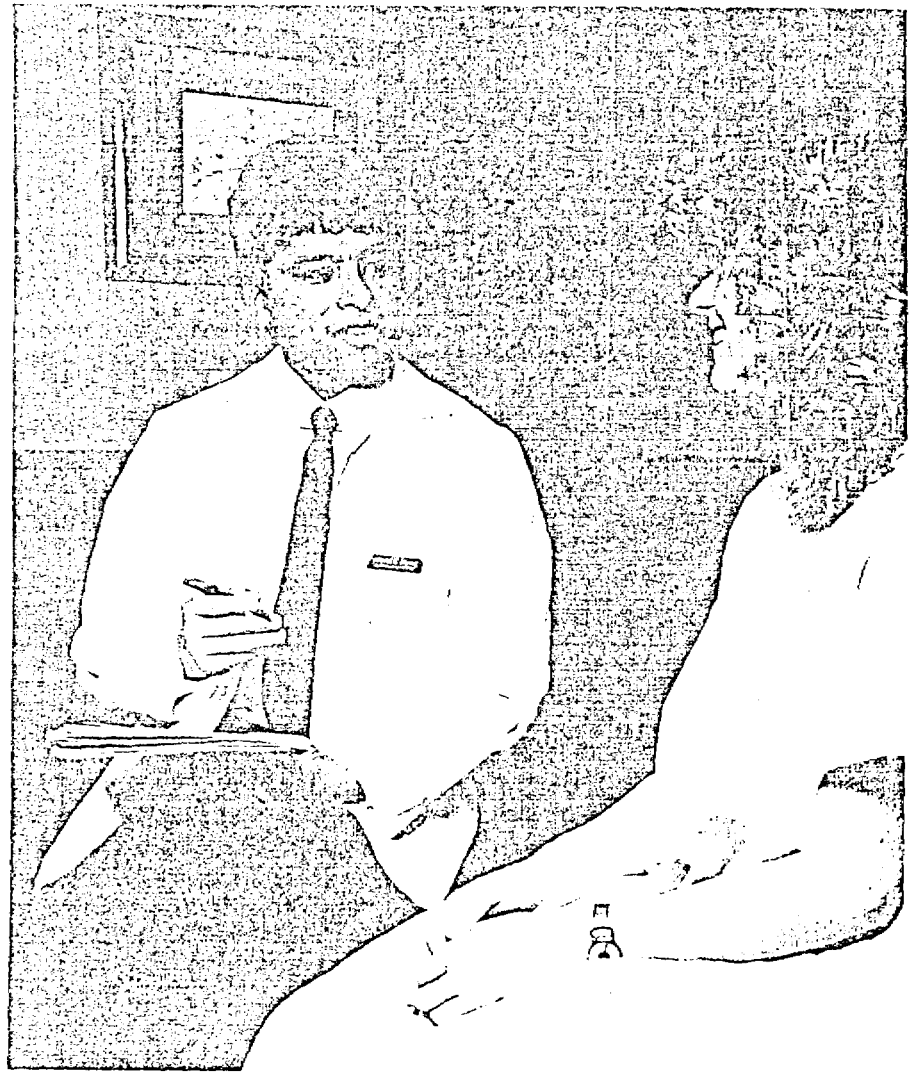

EXHIBIT NO. #2
DATE 3/1/89
BILL NO. HB 33 CORE

FRESHMAN YEAR

Quarter 1	Course #	Hours /Week	Units
Gross Anatomy I	AN 111	14	10
Human Histology	AN 112	5	4
Human Embryology	AN 113	3	3
Terminology	PH 111	1	1
Roentgenographic Anatomy I	XR 111	5	4
Chiropractic Philosophy and Principles I	PP111	3	3
		31	25
Quarter 2			
Gross Anatomy II	AN 121	11	8
Fundamentals of Physiology	PH 121	7	6
Biophysics	PS 121	4	4
Biochemistry I	PS 122	5	5
Roentgenographic Anatomy II	XR 121	4	3
Introduction to Research	PS 123	3	3
		34	29
Quarter 3			
Neuroanatomy	AN 131	6	5
Spinal Anatomy	AN 132	2	2
Cardiovascular Physiology	PH 131	5	5
Biochemistry II	PS 131	8	6
Microbiology I	MP 131	4	4
General Pathology I	MP 132	4	4
Introduction to Chiropractic Science	PP131	4	3
		33	29

SOPHOMORE YEAR

Quarter 4			
Renal and Pulmonary Physiology	PH 211	5	5
Neurophysiology	PH 212	5	5
Microbiology II	MP 211	6	4
General Pathology II	MP 212	3	3
Chiropractic Procedures I	PP211	7	5
Research Methodology	PS 211	3	3
Lower Extremities	PP212	2	1
		31	26
Quarter 5			
Special Senses	AN 221	3	3
Gastrointestinal and Metabolic Physiology	PH 221	4	4
Endocrinology and Reproductive Physiology	PH 222	3	3
Neuromusculoskeletal Pathology	MP 221	5	5
Neuromusculoskeletal Pathology Laboratory	MP 222	2	1
Cardiovascular-Pulmonary Pathology	MP 223	4	4
Cardiovascular-Pulmonary Pathology Laboratory	MP 224	2	1
Chiropractic Philosophy and Principles II	PP221	3	3
Chiropractic Procedures II	PP222	6	5
		32	29
Quarter 6			
Nutrition and Dietetics	PH 231	5	5
Toxicology	PS 231	3	3
Gastrointestinal and Urogenital Pathology	MP 231	4	4
Gastrointestinal and Urogenital Pathology Laboratory	MP 232	1	1
Public Health	MP 233	6	6

Neoplasms and Genetic Disorders	MP 234	3	3
Principles of Roentgenology	XR 231	3	3
Chiropractic Procedures III	PP231	6	5
		31	30

JUNIOR YEAR

Quarter 7			
Physical Diagnosis	DX 311	9	8
Orthopedics	DX312	5	4
Roentgenographic Positioning	XR 311	3	2
Roentgenographic Interpretation	XR 312	4	4
Chiropractic Procedures IV	PP311	8	6
Physical Therapy I	PP312	5	5
		34	29
Quarter 8			
Laboratory Diagnosis	DX 321	6	6
Clinical Chemistry Laboratory	DX 322	4	2
Neurological Diagnosis	DX 323	6	6
Ear, Eye, Nose and Throat	DX 324	3	3
Chiropractic Procedures V	PP321	6	5
Physical Therapy II	PP322	5	4
Introduction to the Clinical Experience	CP321	2	2
		32	28
Quarter 9			
Spinal Traumatology	DX 331	5	5
Differential Diagnosis	DX 332	8	8
Obstetrics and Gynecology	DX 333	6	6
Chiropractic Procedures VI	PP331	4	4
Communication of Chiropractic Philosophy and Principles	CP331	3	3
Clinic I	CP332	4	3
		30	29

SENIOR YEAR

Quarter 10			
Geriatrics	DX 411	3	3
Dermatology and Syphilology	DX 412	3	3
Pediatrics	DX 413	5	5
Clinical Diagnostic Seminar	DX 414	4	4
Emergency Procedures	PP 411	5	4
Ethics and Jurisprudence	CP 411	4	4
Clinic II	CP 412	6	3
		30	26

Quarter 11			
Management of the Chiropractic Practice	CP 423	3	3
Clinical Diagnostic Seminar	DX 421	3	3
Clinical Psychology	CP 421	3	3
Clinic III	CP 422	22	11
		31	20

Quarter 12			
Clinical Diagnostic Seminar	DX 431	4	4
Chiropractic Philosophy and Principles III	PP 431	3	3
Clinic IV	CP 432	23	12
		30	19

THE DISCIPLINES

Discipline of Anatomy (AN)	Course #	Hrs/Qtr	Units
Gross Anatomy I	AN 111	168	10
Human Histology	AN 112	60	4
Human Embryology	AN 113	36	3
Gross Anatomy II	AN 121	132	8
Neuroanatomy	AN 131	72	5
Spinal Anatomy	AN 132	24	2
Special Senses	AN 221	36	3

Discipline of Physiology (PH)			
Terminology	PH 111	12	1
Fundamentals of Physiology	PH 121	84	6
Cardiovascular Physiology	PH 131	60	5
Renal and Pulmonary Physiology	PH 211	60	5
Neurophysiology	PH 212	60	5
Gastrointestinal and Metabolic Physiology	PH 221	48	4
Endocrinology and Reproductive Physiology	PH 222	36	3
Nutrition and Dietetics	PH 231	60	5

Discipline of Physical Sciences (PS)			
Physics	PS 121	48	4
Biochemistry I	PS 122	60	5
Introduction to Research	PS 123	36	3
Biochemistry II	PS 131	96	6
Toxicology	PS 231	36	3
Research Methodology	PS 421	36	3

Discipline of Microbiology/Pathology (MP)			
Microbiology I	MP 131	48	4
General Pathology I	MP 132	48	4
Microbiology II	MP 211	72	4
General Pathology II	MP 212	36	3
Neuromusculoskeletal Pathology	MP 221	60	5
Neuromusculoskeletal Pathology Laboratory	MP 222	24	1
Cardiovascular-Pulmonary Pathology	MP 223	48	4
Cardiovascular-Pulmonary Pathology Laboratory	MP 224	24	1
Gastrointestinal and Urogenital Pathology	MP 231	48	4
Gastrointestinal and Urogenital Pathology Laboratory	MP 232	12	1
Public Health	MP 233	72	6
Neoplasms and Genetic Disorders	MP 234	36	3

Discipline of Diagnosis (DX)			
Physical Diagnosis	DX 311	108	8
Orthopedics	DX 312	60	4
Laboratory Diagnosis	DX 321	72	6
Clinical Chemistry Laboratory	DX 322	48	2
Neurological Diagnosis	DX 323	72	6
Ear, Eye, Nose and Throat	DX 324	36	3

Spinal Traumatology	DX 331	60	5
Differential Diagnosis	DX 332	96	8
Obstetrics and Gynecology	DX 333	72	6
Geriatrics	DX 411	36	3
Dermatology and Syphilology	DX 412	36	3
Pediatrics	DX 413	60	5
Clinical Diagnostic Seminar	DX 414	48	4
Clinical Diagnostic Seminar	DX 421	36	3
Clinical Diagnostic Seminar	DX 431	48	4
Discipline of Roentgenology (XR)			
Roentgenographic Anatomy I	XR 111	60	4
Roentgenographic Anatomy II	XR 121	48	3
Principles of Roentgenology	XR 231	36	3
Roentgenographic Positioning	XR 311	36	2
Roentgenographic Interpretation	XR 312	48	4
Discipline of Principles and Procedures (PP)			
Chiropractic Philosophy and Principles I	PP111	36	3
Introduction to Chiropractic Sciences	PP131	48	3
Chiropractic Procedures I	PP211	84	5
Chiropractic Philosophy and Principles II	PP221	36	3
Chiropractic Procedures II	PP222	72	5
Chiropractic Procedures III	PP231	72	5
Chiropractic Procedures IV	PP311	72	5
Physical Therapy I	PP312	60	5
Chiropractic Procedures V	PP321	72	5
Physical Therapy II	PP322	60	4
Chiropractic Procedures VI	PP331	48	4
Emergency Procedures	PP411	60	4
Chiropractic Philosophy and Principles III	PP431	36	3
Lower Extremities	PP223	24	1
Discipline of Clinical Practice (CP)			
Communication of Chiropractic Philosophy and Principles	PP331	36	

Intro. to Clinical Experience	CP321	24	2
Clinic I	PP332	48	3
Ethics and Jurisprudence	PP411	48	4
Clinic II	PP412	72	3
Clinical Psychology	PP421	36	3
Clinic III	PP422	264	11
Management of the Chiropractic Practice	PP431	36	3
Clinic IV	PP432	276	12
Elective Courses			
Diversified Technique	PP440	36	1
Gonstead I	PP441	36	1
Gonstead II	PP442	36	1
Thompson-Terminal Point Technique	PP443	24	1
Upper Cervical Specific	PP444	24	1
Sacro-Occipital Technique	PP445	36	1
Logan Basic Technique	PP446	36	1

COURSE DESCRIPTIONS

Study in the basic sciences provides a learning environment in which students develop the intellectual foundation essential to the study of the clinical sciences, and cognitive skills necessary for scientific inquiry.

Courses are integrated within the curriculum in an order that provides opportunity to acquire a comprehensive background in the structure and function of the human body. Special emphasis is placed upon control mechanisms that govern homeostatic function as an essential factor of health. Additionally, students are introduced to homeostatic imbalance and associated pathomorphology.

• DISCIPLINE OF ANATOMY (AN)

Courses include both gross and microscopic anatomy. Special emphasis is placed on clinical applications of knowledge gained from a complete study of human anatomy.

The series of gross anatomy courses is designed to sequentially present the systems of the body. Special subdivisions of gross anatomy of primary importance to students of chiropractic (e.g. the neuromusculoskeletal system) receive a more detailed examination. Supporting laboratories utilize human cadaveric dissection and prosected cadaveric material.

Microscopic anatomy deals with examination of the human body on the cellular and tissue level in both the developmental and adult stages of life. Supporting laboratories utilize microscopes and series of prepared histologic slides.

AN 111 – Gross Anatomy I
(6 lecture hrs. & 8 lab hrs. per week)
Regional study of the human body, including: body wall and extremities; conceptual approach to fascial compartments; emphasis on clinical correlates. Human dissection laboratory.
Corequisite: XR 111.

DAILY ROLL CALL

HUMAN SERVICES AND AGING COMMITTEE

51st LEGISLATIVE SESSION -- 1989

Date January 4, 1989

NAME	PRESENT	ABSENT	EXCUSED
Stella Jean Hansen	✓		
Bill Strizich	✓		
Robert Blotkamp	✓		
Jan Brown	✓		
Lloyd McCormick	✓		
Angela Russell	✓		
Carolyn Squires	✓		
Jessica Stickney	✓		
Timothy Whalen	✓		
William Boharski	✓		
Susan Good	✓		
Budd Gould	✓		
Roger Knapp	✓		
Thomas Lee	✓		
Thomas Nelson	✓		
Bruce Simon	✓		

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OCT 12 '88 16:31 100 SERIAL #01229 P.04

I. Introduction

Purpose and Objectives

In the period January through May 1985, a national program inspection on Medicare coverage of chiropractic services was conducted by the Region V (Chicago) Office of Analysis and Inspections, Office of the Inspector General, Department of Health and Human Services.

This study was done in response to growing concerns regarding: the rapidly rising cost of chiropractic care under Medicare Part B; the possible implications of previously conducted OIG targeted investigations of chiropractors; an emerging perception that current Medicare legislation and regulations may not be administered in such a way as to provide intended limits on coverage; and a perception by chiropractors and others that the benefit does not adequately cover or reflect current patterns of practice.

The inspection had four general objectives:

- To develop an understanding of chiropractic as a profession as seen by its practitioners, schools and associations, as well as representatives of mainstream medicine.
- To explore with the chiropractic community how current Medicare legislation and regulations affect them and their patients, and in particular to discuss with them how they evaluate the x-ray requirement and handle billing.
- To gather and analyze data on patterns of chiropractic utilization and expenditures under Medicare, Part B.
- To examine how Medicare Part B carriers process chiropractic claims and to determine the effects of their screens and reviews.

Methods

In order to achieve these objectives, the inspection had three major segments:

- On-site discussions were held with 86 organizations and individuals in 13 states and the District of Columbia, selected to provide broad geographic and interest-group participation. Included were representatives of 12 chiropractic colleges, 15 chiropractic associations, 28 medical societies and hospital associations, and 22 third-party payers (Medicare Part B carriers and private payers), as well as representatives of HCFA and other policy experts.

- Telephone discussions were held with a representative sample of 145 chiropractors in eight states, who were randomly selected from lists of providers with billing numbers, provided by randomly selected Part B carriers.

- An analysis was made of the billing and payment histories of chiropractors in the telephone sample for claims processed in calendar year 1983, along with other data on Medicare billing and expenditure patterns provided by Part B carriers and HCFA. (See Appendix A for a discussion of sampling methodology for the telephone survey and the provider history review.)

OCT 12 '88 16:35 100 SERIAL #01329 P.01

II. Overview

What is Chiropractic?

The American Chiropractic Association describes the discipline as follows:

> "Chiropractic is a branch of the healing arts which is concerned with the human health and disease process. Doctors of chiropractic are physicians who consider man as an integrated being but gives special attention to spinal mechanics, neurological, vascular, and nutritional relationships...
>
> Chiropractic is built on three related scientific theories and principals...
>
> 1) Disease may be caused by disturbances of the nervous system ...
>
> 2) Disturbances of the nervous system may be caused by derangements of the musculoskeletal structure. Off-centerings (subluxations) of vertebral and pelvic segments represent common mechanical clinical findings in man ...
>
> 3) Disturbances of the nervous system may cause or aggravate disease in various parts or functions of the body ..."
> (American Chiropractic Association, Chiropractic: State of the Art, 1984. pp. 8-9

Medicare Coverage of Chiropractic Services

In 1972, PL 92-603 authorized limited Medicare Part B coverage of chiropractic services. In the final legislation, chiropractors were defined as physicians for coverage purposes, but payment was limited to : "...treatment by means of manual manipulation of the spine (to correct a subluxation demonstrated by x-ray to exist) ..." (Section 1861(r)(5), Social Security Act). There was considerable controversy surrounding the passage of this legislation which was adopted despite the recommendations and concerns about chiropractic as a form of treatment contained in the 1968 HEW report, Independent Practitioners Under Medicare. Almost every mainstream medical group also formally opposed passage.

Educational standards were set for chiropractors and payment could only be made for services provided in states where chiropractors were legally authorized to practice.

The regulations for this benefit further limited coverage to payment "...only for the chiropractor's manual manipulation of the spine to correct a subluxation... which has resulted in a neuromusculoskeletal condition for which manipulation is an appropriate treatment." (42 CFR 405.232b(c). Not included for coverage were other services that chiropractors were licensed in some states to perform, including: an initial diagnostic visit, adjunctive services (physical therapy), routine laboratory work and, most important, x-rays which are required by the legislation to justify treatment.

Utilization of and Expenditure for Chiropractic Services Under Medicare

The national figures on Medicare utilization of chiropractic services show minority but growing demand by the elderly for such care, with a rapid rate of growth for expenditures.

- In calendar year 1984, total Medicare expenditures for chiropractic services were greater than $93.6 million, as compared with $38.2 million in 1979 and $19.2 million in 1975. The average annual rate of growth in Medicare expenditures for chiropractic services between 1975 and 1984 was 18.7%. (An anticipated 50% growth in the number of chiropractors over the next five years will probably increase this rate of growth.)

- A report from the National Medical Care and Utilization Survey (published in 1984 by the National Center for Health Statistics) estimates that in 1980, 5.2% of the U.S. population, age 65 and over, received services from a chiropractor. This is greater than the percentage of persons in this age group which received services from a podiatrist (4.4%), and less than received services from an optometrist (9.2%), a nurse (18.1%) or an MD/DO (76.7%).

- OIG analysis of HCFA's 1983 prevailing charge summary data showed that manual manipulation of the spine was the 9th most frequently billed procedure under Medicare in 1983. This was exceeded only by such routine services as urinalysis, complete blood count, blood sugar, and follow-up hospital and office visits.

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III. Chiropractic Today: A Continuing Paradox

Because heated controversy regarding chiropractic theory and practice continues to exist, it was decided early in the study to examine Medicare issues in the context of how the profession views itself and is viewed by others. On-site and telephone discussions with chiropractors, and their schools and associations, coupled with a review of background materials (many of which were provided by respondents) result in a picture of a profession in transition and containing a number of contradictions.

Growth of Acceptance by Patients and Society

Despite historical opposition from organized medicine, there has been a steady growth in the acceptance of chiropractic as a profession. There are now about 24,000 chiropractors in the United States and in 1985, 9847 students were enrolled in 15 chiropractic colleges. About 4% of the total US population receives some services from a chiropractor each year. As the result of law suits and other pressures, the American Medical Association has revised its code of ethics to allow some cooperation between physicians and chiropractors. Similarly, the Joint Commission on the Accreditation of Hospitals has revised accreditation standards to allow hospitals the option of including chiropractors on their staffs.

Chiropractors have been quite successful in obtaining recognition from Federal and State governments, and have been included in many governmental programs. For example:

- Chiropractors are now licensed in all states, although there is considerable variation in statutory definitions of the profession and of its scope of practice.
- Chiropractic services have limited coverage under Medicare and under Medicaid programs in about half the states. In all states, chiropractic services are covered under worker's compensation programs.
- In 20 states, legislation has been passed which mandates either coverage or offering of coverage of chiropractic services under private health insurance policies.
- Federal financial assistance is available to chiropractic students under the HEAL program. However, chiropractic colleges in general receive no state support.

Professional Organization and Practice

Chiropractors have organized their professional and educational structure into a format which to some extent mirrors mainstream medicine. There are two major (and competing) national organizations, the American Chiropractic Association and the International Chiropractors Association, state and local societies, specialty boards, a national Board of Chiropractic Examiners and a Council on Chiropractic Education which recommends policy and sets accreditation standards for chiropractic colleges across the United States.

Within the profession, there continues to be a debate between "straight" chiropractors who limit their activity to spinal manipulation therapy and "mixers" who use a variety of therapeutic techniques, most often different forms of physical therapy. It is recognized by many chiropractors that elaborate claims for universal efficacy of chiropractic care have been greatly overstated in the past, but there continues to be some disagreement within the profession regarding which conditions are appropriate for chiropractic care and regarding appropriate parameters for treatment.

During the field visits, chiropractors were asked how they viewed their position within the larger health care delivery system, and their relationship with orthodox medicine. The respondents maintained that, for many patients, the chiropractor can and should serve as a sort of gatekeeper, doing an initial diagnostic work up on patients, referring those for which chiropractic care is inappropriate. It is for this purpose that many chiropractors are seeking greater access to hospital diagnostic resources and physical therapy facilities, and expansion of their scope of practice in states where their activity is limited. However, many also conceded that most patients at an initial visit present such complaints as headaches or lower back pain, and view the chiropractor as a specialist dealing with a limited set of conditions.

Many of the respondents stressed the value of expanded scientific inquiry into the efficacy of chiropractic, and welcomed the continued upgrading of curriculum and admission standards at the colleges. They were eager to point out the increased time the colleges have allocated to teaching the basic sciences and stressed the increased numbers of PhDs on their faculties from such disciplines as chemistry, physiology, nutrition, etc.

The Problem Side of Chiropractic

Despite the evidence which was presented during the study regarding the increased emphasis on science and

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professionalism in the training and practice of chiropractors, there also exist patterns of activity and practice which at best appear as overly-aggressive marketing and, in some cases, seem deliberately aimed at misleading patients and the public regarding the efficacy of chiropractic care. Teaching materials provided by one chiropractic college warn students of "cultists" within the profession which on one side are "anti-diagnosis, anti-therapeutics, pseudo-religious and stress one cause/one cure"; and, on the other extreme, use a "plethora of questionable elixirs, pseudo-medical concepts regarding treatment of specific disorders, and practice a variety of (questionable) healing philosophies."

During the study, discussions were held with reform-minded chiropractors who are in the process of forming a separate professional group of practitioners, the National Association of Chiropractic Medicine, that would set strict standards of ethical conduct and practice, and would actively work in cooperation with consumer groups and others to expose and rid the profession of questionable activities. To date, this group appears to have attracted only a small proportion of the profession. During the discussions, some representatives of schools and associations recognized that there continue to be problems with some of the chiropractors, but emphasized their minority status within the profession.

Examples of problem situations gathered during field visits included:

- Practice-building courses, popular with many chiropractors, advocate advertising techniques which suggest the universal efficacy of chiropractic treatment for every ailment known to humans. The chiropractor's staff is encouraged to reinforce this message even in regard to a patient's questioning the continued use of medication and other therapies prescribed by other physicians for life-threatening conditions and venereal disease.

- A newspaper in Iowa published a multi-part story on chiropractic where a reporter visited many chiropractors and got many different conflicting diagnoses and proposed treatment plans.

- There was testimony regarding patients who, on the basis of a limited examination, had been encouraged to sign contracts for a multi-year course of chiropractic therapy (payable in advance by Mastercharge, Visa or in easy installments).

- A major television station in Chicago did an expose of cancer scams which heavily involved chiropractors in Illinois.

Prior to the start of this program inspection, OIG regional studies had uncovered problems with chiropractors via a vis federal programs. Independent studies of chiropractic services conducted by the Chicago, Phildelphia and New York regional offices found serious recordkeeping problems. The office records did not support diagnostic information submitted with the claim; frequently, little else was documented beyond the patient's payment record (i.e. no complaint, no examination notes, no treatment notes or progress notes, no documentation for the taking of or evaluation of x-rays, etc.) Treatments billed for spinal ailments were in fact treatments for sinus problems, bed wetting, crossed eyes, sprained wrist. A review of office records showed patients receiving regular treatment, with little or no change, over long periods of time, some going as far back as late 1960s and early 1970s. In addition:

- For a sample of 21 patients, one New York chiropractor was unable to furnish treatment records for 19 patients, or x-rays for 16 patients.

- A Pennsylvania chiropractor billed Medicaid for the same-day treatment of a nine-member family, with no documentation of such in the office records.

- The Atlanta Regional Office has investigated a chiropractor who, using a medical doctor's provider number and signature stamp, billed Medicare for the x-rays and office visits, and also for physical therapy which was provided (if provided at all) by the chiropractor.

Some of these problems are not unique to chiropractors. But, at a time when chiropractors are pursuing greater legitimacy in the competition for limited health care dollars, caution should be exercised before any changes in coverage are considered.

IV. Chiropractic Under Medicare

The Social Security Act limits Medicare coverage for chiropractic services to "treatment by means of manual manipulation of the spine to correct a subluxation demonstrated by x-ray to exist." Because chiropractic theory regarding illness differed so greatly from mainstream medicine, the x-ray requirement was written into the benefit as an attempt to "control program costs by insuring that a subluxation actually exists" (from a 1978 GAO review of Medicare coverage of chiropractic). The consensus, from the chiropractic community as well as representatives of the health care field, is that the x-ray requirement has not served this purpose. As noted previously, Medicare expenditures for chiropractic services have increased at an annual rate of 18.7% between 1975 and 1984.

The responses in the telephone survey (supported by information gathered during the field visits) brought into question some of the other basic assumptions inherent in the coverage. There was no clear consensus as to what a subluxation is; furthermore, in the telephone survey:

- The majority (81%) stated that, on an older person's x-ray, more "wear and tear," osteoarthritis and osteoporosis will show up, and not subluxations per se.

- The majority of respondents (84%) said that there are subluxations that do not show up on x-rays.

- Nearly half stated that, when billing Medicare, they "could always find something" (by x-ray or physical examination) to justify the diagnosis, or actually "tailored" the diagnosis to obtain reimbursement.

- Many respondents in the telephone survey, in advocating a change in the benefit, volunteered that the majority of their Medicare patients had chronic conditions that would never be corrected, and were receiving what was essentially palliative or maintenance care for those conditions.

These responses raise serious questions as to the extent that Medicare is paying for conditions that do not meet the original intent of the law.

Subluxations and the X-ray Questions

Previous regional studies of selected chiropractors raised serious questions as to whether chiropractors were billing

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only for treatment of subluxations visible on x-rays, as specified by the Medicare benefit. The 1974 ACA guidelines for Medicare claims review (later withdrawn) stated:

> "subluxations ... demonstrable by x-ray represent only a relatively small portion of spinal subluxations treated by Chiropractic Physicians. Clinical subluxations not necessarily demonstrable by x-ray, constitute the majority of spinal subluxations successfully treated by Chiropractic Physicians."

In our current study, the on-site discussions with chiropractic schools and associations went even further. As was summarized at one school: subluxations are a minor part of chiropractic practice, the term itself is out-of-date, and the x-ray requirement is a distortion of chiropractic which forces chiropractors to state a subluxation is present on an x-ray even when it is not.

Based on a 1979 New Zealand study of chiropractic praised by chiropractors in its fairness to their profession, chiropractors in the telephone survey were asked whether there were different categories of subluxations (such as "structural" and "functional") and whether there are subluxations that do not show up on x-rays. According to the New Zealand report, "structural" subluxations are generally visible on x-rays; "functional" subluxations may not be evident on x-rays because they relate to the functioning of a joint, as in impaired range of motion. While no clear consensus emerged around the structural/functional distinction itself, 84% of the respondents in this current study said that there are subluxations that are not visible on a standard x-ray, and their descriptions generally related to function (fixations, hyper/hypo-mobility).

Having gotten a consensus that some subluxations are not visible on x-rays, respondents gave a very different set of answers when asked whether chiropractors do anything different in treatment or billing when a Medicare patient's x-ray does not show a subluxation:

- 29% stated that one could "always find something" on the x-ray to justify the billing, but there was wide divergence as to whether this "something" correlated to the patient's complaint or treatment.

- 10% indicated that if they determined the subluxation by other means (i.e. physical examination and palpation) they billed it as though it appeared on the x-ray;

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- 6% actually said they "adapted" their diagnosis to "what Medicare wants to hear." As one chiropractor said, "Do we change the diagnosis? I'll find a millimeter out of alignment or rotated on any x-ray ... It's called 'the insurance game'... I don't consider it lying - it's just learning how to function within the system ... [for example,] when you get to the allowed number of treatments, change the subluxation up or down one and give a new date of onset."

Examining the responses about the appropriateness of x-rays in relation to the age of patients helps provide at least an internal logic to the apparent contradictions in these responses. Eighty-one percent of the respondents indicated that the older a person, the greater the likelihood of conditions showing up on x-rays; however 87% of this subgroup specified general degeneration of the spine, osteoarthritis, osteoporosis, and <u>not</u> subluxations per se, as the kinds of things that would show up. The implication is that although there are subluxations that do not show up on x-rays, a chiropractor "can always find something" on an older person's x-ray that for Medicare purposes can be related to, or reinterpreted as, a subluxation.

The cost of an x-ray to justify Medicare reimbursement can often exceed the total reimbursement for the treatments themselves. Almost every chiropractor interviewed complained that this high initial expense was unfair to a patient already on a limited income. However, a great many chiropractors, including those who disagreed with the x-ray requirement, admitted that they would x-ray the Medicare age group anyway, either to rule out inappropriate conditions (e.g., cancer) or to protect themselves from malpractice suits. This becomes an important consideration when looking at the requested coverage changes below.

<u>Desire for Expansion of Medicare Coverage.</u>

At the beginning of each telephone interview and again at the end, chiropractors were queried about changes they would like made in the Medicare benefit. Far and away, the biggest response (69%) was for coverage/reimbursement of x-rays. Thirty-one percent felt the x-ray requirement should be changed or eliminated, but many felt the x-ray should be reimbursed even if the requirement were dropped. From the discussion in the previous paragraph, it is unclear whether dropping the x-ray requirement will result in significantly fewer x-rays. Any shifting of x-ray costs from the patient to the program could mean substantial increases in Medicare expenditures.

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Thirty-seven percent of the respondents felt that Medicare should expand coverage to include more or all of the chiropractors' scope of practice (i.e. what they had been taught and are licensed to perform). Linked with this group were 17% who specifically wanted coverage for physical therapy by chiropractors, 8% who wanted coverage for the initial examination, and 13% who wanted parity in coverage and/or reimbursement with mainstream medical practitioners. 18% recommended the liberalization or elimination of the limits on the number of allowable visits. The implementation of any of these recommendations would result in significant increases in Medicare payments, with no new effective control over quality or quantity of services.

The chiropractic schools and professional associations voiced support for all of these changes. In addition, many school representatives spoke of the need for federal funding for research, comparable to the research money available to medical schools.

As noted previously, it is unclear to what extent Medicare now pays for treatment of conditions that do not meet the original intent of the law. The chiropractic community seems to sidestep rather than clarify the ambiguities involved in the current program while requesting a major increase in coverage and costs for the Medicare program.

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V. Billing and Payment Patterns for Chiropractors in the Sample

The actual pay-out of Medicare dollars for chiropractic services depends on both the volume and variety of claims which are submitted for payment and on how Part B carriers review and process them. There are differences in treatment philosophy and practice between chiropractors (as well as differences in patient preference) which result in a wide variance in both the number of services billed and in the types of covered and non-covered services that are included. As indicated above, there is a significant (but undetermined) volume of billing for correction of subluxations that do not show up on an x-ray.

Carriers have systems in place to deny claims for some non-covered services (e.g. physical therapy) but not others (e.g. manipulation of the spine where the subluxation is not demonstrated by x-ray). They have no common standards to determine the appropriate frequency of covered services and there is little consistency among carriers in the number of covered services per patient that are approved for payment. Less than 6% of all services billed are denied for utilization reasons. Because claims for chiropractic care include many services at small cost, and because the review of claims (beyond determination of completeness, and whether a service is covered) is labor intensive and expensive, carriers seldom review actual x-rays or office records. Denial of claims flagged by utilization screens has relatively little effect on Medicare payout. (See Appendix B for a more detailed discussion of these patterns than is presented below.)

Billing Patterns

The average number of services billed for a patient in the sample was 13.4 and the average number allowed for payment was 10.4. The average total dollars billed for a patient was $224, the average allowed was $131 and the average paid was $87. The average number of Medicare patients served by a chiropractor in the sample was 39.

These averages, however, mask the diversity across the full range of the scale. At the low end, about 28% of the patients only received between 1 and 5 services in a year that were billed to Medicare. At the high end, however, 19% of the patients received more than 20 services, almost half (47%) of all services billed. In the sample 14.3% of the chiropractors on average billed for more than 20 services for each Medicare patient seen.

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Payment Patterns by Carriers

The Medicare Carriers Manual recognizes the somewhat ambiguous position of chiropractic and states that:

> "Implementation of the chiropractic benefit requires an appreciation of the disparate orientation of chiropractic theory and experience and those of traditional Medicine since there are fundamental differences regarding the etiology and theories of the pathogenesis of disease" (Sec. 2250)

The manual presents a system for classifying subluxations, a general discussion of treatment parameters and a schema for relating various symptoms to a particular area of the spine. The manual also lists examples of conditions for which manual manipulation of the spine is not an appropriate treatment. Some critics have suggested that this system has provided a blueprint for some chiropractors to work backward to identify the appropriate location of a subluxation for billing purposes, as opposed to treating and billing for a subluxation which has been identified on an x-ray.

Claims for payment for chiropractic services must include a statement of diagnosis and symptoms, specify the precise level of the spinal subluxation and must indicate that an x-ray film is available for carrier review. The carriers appear to spend a considerable amount of time assuring that the documentation on the claim is complete, but seldom is an actual x-ray or office record reviewed. Most carriers have instituted automated systems which (if the procedure is coded correctly) reject claims for non-covered services such as x-ray or physical therapy. The carriers have set up their own frequency parameters which flag for review the claims of patients whose number of covered services exceeds the carrier's established thresholds for review. There is little consistency nationally, and none at all in the sample carriers, regarding these parameters.

In the sample, 22% of all services submitted for payment were denied by the carriers. Of these, 16.7% were denied more or less automatically because they were duplicate bills or non-covered services, while only 5.3% were denied because they exceeded frequency parameters or failed to meet other utilization review criteria. There was little consistency among carriers in their overall denial rates which ranged in total between 2.7% and 47% of all services. Similarly, denials for non-utilization reasons ranged between 0.3% and 32.2%, and denials for utilization ranged between 0.8% and 14.8%.

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An examination of how individual chiropractors fared in relation to the intensity with which they treated patients or billed for services showed only a limited relationship. Chiropractors that on the average billed for more than 20 covered services per patient per year had 20.6% of their covered services denied, but there was little variation in the percent of covered services denied for groups of chiropractors that on the average billed for 20 or fewer services per patient per year.

In order to bring at least partial consistency to frequency screens, HCFA in the fall of 1984 set up a pilot project which would require some carriers to review all claims for chiropractic care for chronic cases that exceeded one treatment per month. However, there was no common definition provided for chronic care. At the time this study was begun, there had been only partial participation in this project and at least one of the participants had modified HCFA's mandated frequency screens because too many cases would have been selected for additional intensive review.

When processing chiropractic claims, the carriers have had to individually impose administrative order on a situation where the standards for evaluating x-ray documentation are ambiguous and there is no concensus regarding the number of services a patient should receive. It seems clear that the x-ray requirement is ignored by some chiropractors. On a benefit/cost basis, the x-ray requirement may be unenforceable. This suggests the need for a change in the benefit which would provide a workable approach to limiting utilization as originally intended by Congress and which would reflect somewhat more clearly the current realities of chiropractic practice.

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VI. Recommendations

- HCFA and the Department should vigorously oppose any movement to expand the coverage of chiropractic services to include an initial diagnostic visit, x-ray, laboratory services or adjunctive therapy. In the absence of effective utilization controls, the cost of these proposals would more than double the cost of chiropractic care under the Medicare benefit in the next several years (from $93.6 million in CY 84 to more than $260 million in CY 87.)

Legislation was introduced in the 98th Congress which would remove the x-ray requirement for justifying chiropractic services and would expand Medicare coverage to payment for an appropriate x-ray, physical examination and related routine lab tests. Chiropractic associations and individual practitioners would also like to see coverage of adjunctive (physical therapy) services.

The financial impact of expansion would be great. A survey done by the American Chiropractic Association indicates that in 1984, the median bill for an initial visit to a chiropractor, including diagnostic tests, x-ray etc, was about $110. If bills at this amount were submitted for only half of the patients seen by chiropractors in the sample (and paid at 80%), the Medicare expenditures for the sample would increase more than 50%. Coverage of physical therapy would at a minimum increase cost by another 16% (the amount denied by carriers in the sample for non-covered services). Under an expanded program, (and assuming an annual rate of growth in the cost of chiropractic services of 18.7%) it is projected that in CY 87, total annual cost to Medicare for chiropractic services would more than double to $260 million. Given Medicare history relative to coverage of other physical therapy services, and the 50% expected increase in chiropractors over the next five years, the amount would probably be greater.

- HCFA and the Department should consider submitting a legislative proposal to Congress which would:

  - Continue to limit Medicare coverage of chiropractic services to manual manipulation of the spine to correct a subluxation demonstrated by x-ray to exist.

  - Cap the number of services for which a patient could receive payment at 12 per year. All covered services over 12 visits would be automatically denied. ($23.9 million savings in CY 87.)

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The carriers have in place systems which for the most part routinely deny payment for non-covered services, such as x-ray, laboratory tests or physical therapy, provided by chiropractors. However the requirement that Medicare cover only the treatment of those subluxations demonstrated by x-ray is not well enforced and may be unenforceable. Although the chiropractors in this study admit they sometimes bill for services in cases where the subluxation is not clearly demostrated by x-ray, the carriers have not found x-ray review to be cost effective. This is because there is little agreement among carriers, chiropractors or others regarding the criteria which should be used to determine which conditions of the spine (shown on an x-ray) are actually subluxations which require treatment. X-ray review is also labor intensive, relatively expensive and often the last step in the process of determining which claims should be paid.

In addition, the carriers indicate that even when an x-ray clearly shows a subluxation, there are no agreed upon standards regarding the appropriate number of services (manipulations) required to treat a given acute or chronic condition. Similarly, neither national chiropratic association has approved or endorsed any utilization review criteria. Given the ineffectiveness of these brakes on costs and utilization, a 12 service per year cap is recommended.

The impact of a 12 service cap on patients would be minimal. It would allow patients with chronic conditions one treatment a month and would encompass the number of services provided to a majority of the patients needing acute care. (Over two thirds of the patients in the sample received less than 12 covered services per year.) Patients who do not respond after 12 treatments would still have the option of seeking additional services in the traditional medical care system. The cap would also provide both patients and chiropractors with a known level of coverage against which treatment decisions could be made. The imposition of a cap would be similar to the dollar limitation which has been imposed on outpatient psychiatric services and on services provided by independent physical therapists.

In December 1985, HCFA mandated all carriers to implement a screen on chiropractic claims set at 12 services per year.

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The manual issuance requires that "[m]edical necessity determinations must be made on all claims where the parameters are exceeded." Carriers are required to "[r]eview both those claims which exceed the parameters and those which do not." However there remains the question of what standards should be used to evaluate these claims.

If this screen is implemented with a level of development and review sufficient to deal with the problems raised by this inspection, the burden on the carriers could be quite heavy. We estimate that between 31% and 56% of the Medicare patients receiving chiropractic services will have their claims examined. This is the range between the proportion of patients with 12 or more approved services and the proportion with 12 or more billed services. Some will require more than one review because they will submit claims after the first batch of 12 is examined or because they are treated for more than one acute episode.

If a well developed review (with examination of an x-ray) costs at least $10, if 5.2% of the 31 million Medicare patients with part B coverage see a chiropractor each year, if 43.5% require review, and if each patient in the sample is reviewed 1.5 times, then the annual cost to the carriers will be $10.5 million. Since HCFA requires a 5 to 1 return on medical review/utilization review, the cariers would have to reduce total chiropractic pay out almost 50% to meet the standard. It may be argued that some reviews can be done for less than $10, but these would involve no additional contact with the chiropractor, no x-ray review and no consideration of evidence other than that which is submitted on the face of the claim.

Based on sample data, a 12-visit cap would annually save about 8.6% in Medicare expenditures for chiropractic services. Assuming an 18.7% annual rate of growth of the billings for chiropractic services, this would amount to about $13.4 million in savings from reduced payment for services in CY 87. To this can be added a reduction of $10.5 million per year, the estimated additional cost of the HCFA mandated screens, for a total savings of $23.9 million a year. (See Appendix C for a further discussion of the derivation of the impact of the cap.)

- The Department should examine the ways in which it can further encourage the submission of scientific research proposals by chiropractic colleges, which meet the standards applied to other projects supported by the National Institutes of Health.

There continues to be a debate within the chiropractic profession, and with outside observers, regarding the extent to which chiropractic should be accepted and judged only by the internal standards of the profession. This discussion has been influenced by the separatist approach which chiropractors have historically maintained and by their reaction to criticism from organized medicine.

As chiropractors seek access to mainstream resources and look for acceptance by a larger portion of the society, there would be value for all parties in finding a meeting ground where issues could be examined within a common set of ground rules and definitions. Increased access to research funding by chiropractic colleges would provide one point of mutual interaction between chiropractors and other health professions, and would serve to enhance the position of those segments of the profession that seek to improve the quality of chiropractic education and who would work to limit the use of questionable diagnostic and therapeutic techniques used by some chiropractors.

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Appendix A

Sampling Methodology for Telephone Survey and Review of Provider Histories

In order to obtain a representative sample of carriers, providers and patients for use in the telephone survey and in review of provider histories, the following steps were taken:

(1) OIG headquarters staff obtained from HCFA a print-out of "Part B Expenditures for Chiropractors by Type of Service, Payment Records Processed 1/83 - 12/83." Each carier's percentage of total dollars paid was determined and multiplied times 10,000. Each carrier was assigned sequentially a block of numbers equal to its share of 10,000. Eg, carrier #1 was assigned numbers 1-154, carrier #2, numbers 155 - 245, etc.

(2) Ten numbers from a range of 1 to 10,000 were selected using a random number table, and carriers where selected whose block of numbers encompassed the selected numbers. Because we were sampling with replacement, 6 carriers were selected once and 2 carriers came up twice.

(3) From each carrier that was selected, a list of current chiropractors with provider numbers was requested. Using a random number table, 20 provider numbers were selected from each of the carriers that came up once and 40 chiropractors were selected from the 2 carriers that came up twice.

(4) Of the 200 chiropractors selected, telephone discussions were completed with 145.

(5) A complete provider history for CY 83 was requested for each provider selected. Because the list of provider numbers was current, but the billing histories were over a year old, only 152 provider histories were obtained.

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Appendix D

Expanded Discussion of Treatment, Billing and Payment Patterns for Chiropractors in the Sample

Treatment and Billing Patterns

Of the 200 randomly selected chiropractors, 154 had payment histories indicating services had been billed for one or more Medicare beneficiaries in 1983. The remaining 46 chiropractors had an active Medicare billing number, but no bills had been received for processing because they were not then serving Medicare patients, or had moved, retired or expired. The 154 chiropractors served 5964 patients and provided 79,775 services that were billed to Medicare. The total dollar value of these services billed was $1,337,604, the amount allowed $785,349, and the amount paid $516,499.

- The average number of services billed for a patient was 13.4 and the average number allowed was 10.4.
- The average total dollars billed for a patient was $224, the average allowed $132, and the average paid $87.
- The average number of Medicare patients served by a chiropractor (for which a bill was submitted) was 39.
- The average total number of services billed by a chiropractor for all patients served was 518, and the average number of services allowed and paid was 404.
- The average total dollar value of services billed by a chiropractor was $8686, allowed was, $5100, and paid $3354.

But further consideration should be given to patterns at the high and low ends of the treatment scale. Table 1 below presents a breakdown of patients and services by frequency of services billed per patient. Table 2 illustrates treatment patterns in a somewhat different way by grouping chiropractors according to the average number of services billed for all the patients in their practice, and showing the percent of all patients served by each group of chiropractors and the percent of all billed services that were provided.

Table 1

Number, Percent, and Cumulative Percent of Patients and Services Billed by Number of Services Billed Per Patient

Number of Services Billed	Number of Patients	% of Patients	Cumulative % of Patients in Sample	Number of Services Billed	% of All Services Billed	Cumulati % of Services Billed
1-5	1,688	28.3%	28.3%	5,185	6.5%	6.5%
6-10	1,449	24.3	52.6	9,015	11.3	17.8
11-15	1,038	17.4	70.0	16,035	20.1	37.9
16-20	644	10.8	80.8	11,727	14.7	52.6
21 +	1,145	19.2	100%	37,813	47.4	100%
Total	5,964	100%		79,775	100%	

As indicated in Table 1, about half (52.6%) of the patients in the sample received 10 or fewer services that were billed to Medicare. This is fairly evenly divided between the 28.3% of the patients that received between 1 and 5 services and the 24.3% that received between 6 and 10 services. At the other extreme, 19.2% of the patients received more than 20 services and accounted for almost half (47.4%) of all services billed. The distribution of these high-use patients tapers off fairly quickly, but extends far to the right. For example, 11.7% of the patients received between 21-30 services (25% of all services billed), and 4.1% of the patients received between 31-40 services (11.2% of all services billed). The highest user was a patient that had 153 services billed to Medicare in 1983.

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Table 2

Number, Percent, and Cumulative Percent of Chiropractors, Patients Served and Services Billed by Average Number of Services Billed Per Patient

Average Number of Services Billed Per Patient	Number of Chiro-practors	% of all Chiroprac-tors (Cum. %)	Number of Patients Served	% of all Patients Served (Cum. %)	Number of Services Billed	% of all Services Billed (Cum. %)
1-5	19	12.3% (12.3%)	200	3.4% (3.4%)	807	1% (1%)
>5-10	38	24.7 (37)	1,253	21.0 (24.4)	10,213	12.8 (13.8)
>10-15	55	35.7 (72.7)	2,710	45.4 (69.8)	33,626	42.2 (56)
>15-20	20	13.0 (85.7)	1,315	22 (91.8)	23,309	29.2 (85.2)
>20	22	14.3 (100%)	486	8.2 (100%)	11,820	14.8 (100%)
Total	154	100%	5,964	100%	79,775	100%

Table 2 provides a view of the billing and service patterns of chiropractors in the sample broken out by the relative intensity of their practice - the average number of services billed for each Medicare patient they served. The median chiropractor provided on the average between 10 and 15 services that were billed. At the low end 12.3% of the chiropractors (serving 3.4% of the patients) averaged between 1 and 5 services per patient. At the other end, 14.3% of the chiropractors averaged more than 20 services per patient, served 8.2% of all patients in the sample, and accounted for 14.8% of all services billed.

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There are a number of explanations for these differences in billing patterns. Although Medicare pays only for manual manipulation of the spine, some chiropractors obviously provide other services such as x-ray and adjunctive services which are included on the bills submitted. In addition, there continue to be differences in treatment philosophy between "straights" and "mixers" which might account for some variation. Chiropractors also have differing views regarding which conditions are appropriate for chiropractic treatment and there are indications that a proportion of the profession advocates regular maintenance and preventive care that may not be specifically related to either an acute episode or a specific, chronic condition. There are no commonly accepted frequency parameters for care which have been agreed upon at the national level by the profession, and standards previously adopted have been withdrawn.

An important reason for the variation in frequency which must be considered is patient preference. The high percentage of patients receiving between 1-5 and 6-10 services, suggests that there are a number of elderly persons who go to a chiropractor seeking relief for a particular acute episode or who may see a chiropractor briefly and discontinue treatment. There are also economic incentives (co-payments and deductibles) which would operate to modify utilization all across the scale.

Part B Carrier Processing and Payment of Claims

The actual payment for chiropractic services under Medicare depends on the processing of claims by the Part B carriers. The Medicare Carrier Manual recognizes the somewhat ambiguous position of chiropractic and states that:

> "Implementation of the chiropractic benefit requires an appreciation of the disparate orientation of chiropractic theory and experience and those of traditional medicine since there are fundamental differences regarding the etiology and theories of the pathogenesis of disease." (Sec. 2250)

The Medicare Carrier's Manual presents a system for classifying subluxations, a very general discussion of treatment parameters and a schema for relating various symptoms to a particular area of the spine. The manual also lists examples of conditions for which manual manipulation of the spine is not an appropriate treatment, e.g. rheumatoid arthritis, muscular distrophy, multiple sclerosis, emphysema, etc. Some critics have suggested

that this system provides a blueprint for some chiropractors to work backward to identify the appropriate location of the subluxation based on a complaint, as opposed to treating a subluxation which has been identified on an x-ray or by other means.

Claims for payment of chiropractic services require more documentation than is required for comparable services provided by an MD or DO. In addition to a statement of a diagnosis and symptoms, a claim for chiropractic services must:

> "Specify the precise level of spinal subluxation, contain certification on all bills by the treating chiropractor that an x-ray film is available for carrier review demonstrating a subluxation at the specified level of the spine; and include identification of the treatment phase and adjustment - e.g. second, fifth, tenth treatment." (Sect. 4118B)

The carriers appear to spend a considerable amount of time assuring that written documentation is available on the face of the claim submitted. Claims without this documentation should routinely be denied. But only in the most unusual cases is there any review of a chiropractor's actual office records to compare what is written on the claim with what has been recorded in the patient's history. Seldom is an actual x-ray film reviewed. One chiropractor that serves on a carrier professional review committee, interviewed as part of the field study, discribed the quality of some office records and x-rays that he had reviewed as an embarassment to the profession.

Most of the carriers have instituted claims processing systems which should (if the procedure is coded correctly) easily and automatically reject all claims for non-covered services such as x-ray, laboratory or physical therapy provided and billed by a chiropractor. As indicated and discussed further below, over 75% of all the rejections of services for payment are on the basis of lack of documentation or for submission for payment of a non-covered service.

Once non-covered services have been eliminated, the covered manual manipulation of the spine services are evaluated for necessity. The carriers have set up their own frequency parameters which flag for review the claims of patients whose number of covered services exceeds the carrier's established limits. There is little consistency nationally, and none at all among the carriers in the sample, regarding these frequency screens.

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In order to bring at least partial consistency to these frequency screens, HCFA in the fall of 1984 set up a pilot project, which would require some carriers to review all claims for chiropractic care for chronic cases which exceeded one treatment per month. However, there was no common definition provided for chronic cases. At the time this study was begun, there had been only partial participation in this pilot project, and at least one of the participants had modified HCFA's mandated frequency screens because too many cases would have been selected for additional intensive review.

The extreme variation in dealing with chiropractic claims among carriers in the sample is illustrated in Table 3 below which presents the number and percent of services denied by each carrier in its sample, broken down by "Non-UR" (non-covered services, etc) and UR (Exceeding frequency screens, etc.) reasons.

Table 3

Number of Services Billed and Number and Percentage of Services Denied by Non-Utilization Review and Utilization Review Categories.

Carrier	Services Billed In Sample	Number and % of Services Denied		
		Non-UR (%)	UR (%)	Total (%)
A	10,972	37 (0.3%)	265 (2.4%)	302 (2.7%)
B	9,979	556 (5.6)	661 (6.6)	1,217 (12.2)
C	4,698	177 (3.8)	247 (5.3)	424 (9.0)
D	10,418	2,280 (21.9)	147 (1.4)	2,427 (23.3)
E	14,430	3,904 (27.1)	122 (0.8)	4,026 (27.9)
F	11,805	1,553 (13.2)	960 (8.1)	2,513 (21.3)
G	10,073	3,245 (32.2)	1,493 (14.8)	4,738 (47.0)
H	7,400	1,600 (21.6)	351 (4.7)	1,951 (26.3)
Total	79,775	13,352 (16.7%)	4,246 (5.3%)	17,598 (22.0%)

As indicated in Table 3, 22% of all billed chiropractic services presented for payment are denied. This ranges among carriers from 2.7% to 47.0%. Denial rates for non-UR reasons range from 0.3% to 32.2%, and averages 16.7% Denial for UR reasons range from 0.8% to 14.8% and averages 5.3%. Over 75% of all denials are for non-UR reasons; that is, the services were not covered by Medicare. Less than 25% are because the number of services provided exceeded one of the various frequency screens. Given the low dollar amount paid per chiropractic service, low rate of UR denial and the high cost of development, the IG seriously questions the cost effectiveness of edits in controlling chiropractic utilization.

Another way of considering the carrier's handling of claims is to examine the patterns of denials for utilization reasons after claims for non-covered services and duplicate bills have been removed. Table 4 below shows distribution of chiropractors, the number of patients they serve and services they bill arrayed by the relative intensity of covered services (total services billed less non-covered services) which they bill. It also shows the relative denial rates for covered services which were billed.

Table 4

Number and Percent of Chiropractors, Patients Served and Services Billed after Denial for Coverage; and Percent of Services Denied for Utilization Review Reasons by Average Number of Services Billed per Patient after Denial for Non-covered Services

Average Number of Services Billed Per Patient After Denial for Non-covered Services	Number of Chiropractors (%)	Number of Patients Served (%)	Number of Services Billed After Denial for Coverage (%)	Percent of Services Denied for UR
1-5	21 (14%)	284 (4.8%)	1,103 (1.7%)	1.5%
>5-10	56 (38)	2,155 (36.2)	16,769 (25.2)	4.1
>10-15	49 (33)	2,308 (38.7)	28,246 (42.5)	7.7
>15-20	15 (10)	1,117 (18.7)	17,986 (27.1)	5.0
>20	7 (5)	93 (1.6)	2,319 (3.5)	20.6
Total	148 (100%)	5,957 (100%)	66,423 (100%)	6.4%

As indicated in Table 4, over 10% of the chiropractors in the sample (serving 18.7% of the patients) bill for an average of between 15-20 covered services (manual correction of a subluxation) per year. Approximately 5% of the chiropractors (serving about 1.6% of the patients) bill for an average of more than 20 services per year. As would be expected, the carriers rejected for payment only 1.5% of the covered services billed by chiropractors who bill for between 1-5 services per patient. There is relatively little difference in the denial rates for providers who billed between 5-10, 10-15 and 15-20 services per year. The carriers denied 20.6% of covered services for chiropractors that billed for more than 20 services.

Across the board, however, there is no statistical relationship between the average number of covered services billed and the denial rate for services that exceed frequency parameters. That is, knowing the relative intensity with which a chiropractor provides covered services to his patients does not allow one to predict at what rate services will be denied because frequency or other UR screens are exceeded.

Appendix C

Estimation of the Effect of a 12 Service Cap

1) For the 152 chiropractors in the sample that billed patients for one of more services in CY 83, the following information was gathered: total number of services billed and allowed; total dollars billed, allowed and paid; total number of patients served; total number of services denied for (a) utilization and (b) non-utilization reasons, and total dollar value of services denied for (a) utilization reasons.

2) It was assumed that the effect of a cap could only be projected on the basis of a reduction in allowed services and allowed dollars. That is, no credit could be taken for any reduction in billed services that the carriers would have made had there not been a cap in effect.

3) The average number of allowed services per patient (total allowed services/total patients served) was determined for each chiropractor. The chiropractors were divided into two groups: (A) chiropractors with an average number of allowed services equal to or less than 12 and (B) chiropractors with an average number of allowed services greater than 12.

4) A new variable (total dollars paid after the cap) was created for each chiropractor. For chiropractors in the (3A) group (providers with an average number of services allowed per patient equal to or less than 12):

Total dollars paid after the cap =
Total dollars paid.

For chiropractors in the (3B) group (providers with an average number of services allowed greater than 12.

Total dollars paid after the cap =
12 X Total patients served x (Total dollars paid/Total services allowed).

(5) The Percent of dollars saved under the cap =

$$1 - \left(\frac{\text{Weighted} \sum (\text{Total dollars paid after cap})}{\text{Weighted} \sum (\text{Total dollars paid})} \right) = .085.$$

(6) Because of the lack of availability of data, we were forced to make the final estimate of savings based on the average number of services billed. We know that some patients served by chiropractors with an average number of services per patient allowed equal to or less than the cap, had allowed services greater than the cap; and that some patients served by chiropractors with an average number of services allowed per patient greater than the cap have an allowed number of services less than the cap. For purposes of computation it is assumed these two groups would balance out.

(7) The projected dollar savings for 1987 assumed a 18.7% annual rate of growth and was computed as follows:

Dollar savings in CY 87 =

1984 Medicare expenditures for chiropractic services x
Annual rate of growth for three years x
Percent of dollars saved under the cap =

$93.6 million x(1.187 x 1.187 x 1.187) x .085 =

$13.3 million.

From The Executive Office
Montana Medical Association

Highlights of "Inspection of Chiropractic Services Under Medicare"

The regulations for this benefit further limited coverage to payment "...only for the chiropractor's manual manipulation of the spine to correct a subluxation... which has resulted in a neuromusculoskeletal condition for which manipulation is an appropriate treatment."

> OIG analysis of HCFA's 1983 prevailing charge summary data showed that manual manipulation of the spine was the 9th most frequently billed procedure under Medicare in 1983. This was exceeded only by such routine services as urinalysis, complete blood count, blood sugar, and follow-up hospital and office visits.

Within the profession, there continues to be a debate between "straight" chiropractors who limit their activity to spinal manipulation therapy and "mixers" who use a variety of therapeutic techniques, most often different forms of physical therapy. It is recognized by many chiropractors that elaborate claims for universal efficacy of chiropractic care have been greatly overstated in the past, but there continues to be some disagreement within the profession regarding which conditions are appropriate for chiropractic care and regarding appropriate parameters for treatment.

The respondents maintained that, for many patients, the chiropractor can and should serve as a sort of gatekeeper, doing an initial diagnostic work up on patients, referring those for which chiropractic care is inappropriate.

...many also conceded that most patients at an initial visit present such complaints as headaches or lower back pain, and view the chiropractor as a specialist dealing with a limited set of conditions.

...there also exists patterns of activity and practice which at best appear as overly-aggressive marketing and, in some cases, seem deliberately aimed at misleading patients and the public regarding the efficacy of chiropractic care. Teaching materials provided by one chiropractic college warn students of "cultists" within the profession which on one side are "anti-diagnosis, anti-therapeutics, pseudo-religious and stress one cause/one cure"; and, on the other extreme, use a "plethora of questionable elixirs, pseudo-medical concepts regarding treatment of specific disorders, and practice a variety of (questionable) healing philosophies."

EXHIBIT 3
DATE 1-4-89
HB 33

During the study, discussions were held with reform-minded chiropractors who are in the process of forming a separate professional group of practitioners, the National Association of Chiropractic Medicine, that would set strict standards of ethical conduct and practice, and would actively work in cooperation with consumer groups and others to expose and rid the profession of questionable activities. To date, this group appears to have attracted only a small proportion of the profession.

> Practice-building courses, popular with many chiropractors, advocate advertising techniques which suggest the universal efficacy of chiropractic treatment for every ailment known to humans. The chiropractor's staff is encouraged to reinforce this message even in regard to a patient's questioning the continued use of medication and other therapies prescribed by other physicians for life-threatening conditions and venereal disease.
>
> A newspaper in Iowa published a multi-part story on chiropractic where a reporter visited many chiropractors and got many different conflicting diagnoses and proposed treatment plans.
>
> There was testimony regarding patients who, on the basis of a limited examination, had been encouraged to sign contracts for a multi-year course of chiropractic therapy (payable in advance by Mastercharge, Visa or in easy installments).
>
> A major television station in Chicago did an expose of cancer scams which heavily involved chiropractors in Illinois.

The office records did no support diagnostic information submitted with the claim; frequently, little else was documented beyond the patient's payment record (i.e. no complaint, no examination notes, no treatment notes or progress notes, no documentation for the taking of or evaluation of x-rays, etc.) Treatment billed for spinal ailments were in fact treatments for sinus problems, bed wetting, crossed eyes, sprained wrist. A review of office records showed patients receiving regular treatment, with little or no change, over long periods of time, some going as far back as late 1960s and early 1970s.

Some of these problems are not unique to chiropractors. But,, at a time when chiropractors are pursuing greater legitimacy in the competition for limited health care dollars, caution should be exercised before any changes in coverage are considered.

The Social Security Act limits Medicare coverage for chiropractic services to "treatment by means of manual manipulation of the spine to correct a subluxation demonstrated by x-ray to exist." Because chiropractic theory regarding illness differed so greatly from mainstream medicine, the x-ray requirement was written into the benefit as an attempt to "control program costs by insuring that a subluxation actually exists"... The consensus, from the chiropractic community as well as representatives of the health care field, is that the x-ray requirement has not served this purpose.

> The majority (81%) stated that, on an older person's x-ray, more "wear and tear," osteoarthritis and osteoporosis will show up, and <u>not subluxations</u> per se.
>
> The majority of respondents (84%) said that there are subluxations that <u>do not</u> show up on x-rays.
>
> Nearly half stated that, <u>when billing Medicare</u>, they "could always find something" (by x-ray or physical examination) to justify the diagnosis, or actually "tailored" the diagnosis to obtain reimbursement.

These responses raise serious questions as to the extent that Medicare is paying for conditions that do not meet the original intent of the law.

> "subluxations ... demonstrable by x-ray represent only a relatively small portion of spinal subluxations treated by Chiropractic Physicians. Clinical subluxations not necessarily demonstrable by x-ray, constitute the majority of spinal subluxations successfully treated by Chiropractic Physicians."
>
> 29% stated that one could "always find something" on the x-ray to justify the billing, but there was wide divergence as to whether this "something" correlated to the patient's complaint or treatment.
>
> 10% indicated that if they determined the subluxation by other means (i.e. physical examination and palpation) they billed it as though it appeared on the x-ray;
>
> 6% actually said they "adapted" their diagnosis to "what Medicare wants to hear." As one chiropractor said, "Do we change the diagnosis? I'll find a millimeter out of alignment or rotated on any x-ray... It's called 'the insurance game'... I don't consider it lying - it's just learning how to function within the system ... {for example,} when you get to the allowed number of treatments, change the subluxation up or down one and give a new date of onset."

The implication is that although there are subluxations that do not show up on x-rays, a chiropractor "can always find something" on an older person's x-ray that for Medicare purposes can be related to, or reinterpreted as, a subluxation.

...and 13% who wanted parity in coverage and/or reimbursement with mainstream medical practitioners.

MINUTES

MONTANA SENATE
51st LEGISLATURE - REGULAR SESSION

COMMITTEE ON PUBLIC HEALTH, WELFARE AND SAFETY

Call to Order: By Chairman Tom Hager, on March 1, 1989, at 1:00 p.m., State Capitol

ROLL CALL

Members Present: Senators Tom Hager, Chairman; Tom Rasmussen, Vice Chairman; J. D. Lynch, Matt Himsl, Bill Norman, Harry H. McLane

Members Excused: Bob Pipinich

Members Absent: None

Staff Present: Tom Gomez, Legislative Council
Dorothy Quinn, Committee Secretary

Announcements/Discussion: None

HEARING ON HOUSE BILL 33

Presentation and Opening Statement by Sponsor:
Representative Bob Pavlovich, House District #72, stated that HB 33 was requested by the Chiropractic Association. He advised that this bill allows a chiropractor to be an impairment evaluator. The bill has been amended, and he stated he had people to testify regarding this bill.

List of Testifying Proponents and What Group they Represent:

Gary Blom, D.C., Montana Chiropractic Association
Lee Hudson, D.C., DABCO, Mt. Chiropractic Association
Michael Pardis, D.C., Mt. Chiropractic Association
Katrina Martin, speaking for Norman H. Grosfield, Attorney
Bonnie Tippy, Montana Chiropractic Association

List of Testifying Opponents and What Group They Represent:

George Wood, Montana Self Insurers Association
Oliver Goe, Attorney, Montana Municipal Insurance Authority

Testimony:

Dr. Gary Blom stated he is a chiropractor from Helena and past president of the Montana Chiropractors Association. He stated that impairment ratings are basically evaluations that are defined as appraisal of a patient's condition and the nature and extent of the person's illness or injury. According to Dr. Blom, an impairment rating is performed after the patient has reached maximum medical healing. He was trained to do impairment ratings during his last year of college. He stated he was able to do ratings up until the early 1980's, at which time the Worker's Compensation Judge Reardon decided that chiropractors could no longer rate impairment. He submitted copies of a study which indicated chiropractic costs being more cost effective than medicine (Exhibit #1). He reviewed the written testimony, and urged passage of HB 33.

Dr. Lee Hudson stated he is a chiropractic orthopedist from Great Falls and vice-president of the Montana Chiropractic Association. He advised that chiropractors have been taking care of work-comp cases for many years in Montana, but since the 1980's they have been unable to do ratings. In 1987-88, the Montana Chiropractic Association challenged that ruling in the courts and were unsuccessful because of new laws enacted in 1987 regarding impairment evaluations. It is the task of the legislature to set public policy, and they believe public policy should be that chiropractors should be allowed to do impairment ratings. At this point, a chiropractor's patient who needs an impairment rating must be sent to a medical doctor who may not have the day-to-day history of how that patient has progressed. He stated his group has contacted surrounding states regarding their policy and law. All allow chiropractors to do impairment ratings. They question why Montana's policy is in direct contradiction with almost every other state in the country. He urged the committee to give a favorable report on HB 33.

Michael Pardis, a chiropractor from Helena, stated that HB 33 is a fair bill which gives the injured worker a freedom of choice in choosing the doctor to evaluate his case. Two of the arguments used against chiropractors in the hearing process are (1) this is purely a medical determination; and (2) the whole person must be rated. He stated that "medical" is a generic term in this instance. The argument of the chiropractor not being able to treat the whole person is a non-convincing argument. Chiropractors have extensive training in the health care field,

specializing in the chiropractic field. He furnished copies of information defining the academic program a chiropractor must complete (Exhibit #2). He stated in addition, chiropractors must be certified by the State Board of Chiropractors to do impairment ratings. He believes this is a more stringent requirement than medical doctors have since they just need to be licensed in the state. He feels that impairment ratings are not something that should belong to one domain. He pointed out that this will not be a cost factor to Workers Comp or other insurers because there is a set fee defined by the doctor for an evaluation. He urged support of HB 33.

Katrina Martin stated she was standing in for Norman H. Grosfield, an attorney from Helena who represents both claimants and defendants in relation to workers' compensation matters. Mr. Grosfield was unable to appear because of a trial date conflict. In his written testimony, read by Ms. Martin, he urged passage of HB 33. She submitted his testimony (Exhibit #3).

Bonnie Tippy, Executive Secretary at the Montana Chiropractic Association, stated she wished to submit an amendment to the bill, and explained the reasoning behind the amendment (Exhibit #4). She stated this bill is in deference to patients as well as to chiropractors and that they should be able to be rated by a chiropractor. She related statements from various states indicating those states felt chiropractors were qualified to do impairment ratings. She advised they know of no other state which has requirements like Montana's where only medical doctors are allowed to do impairment evaluations. She stated the chiropractors are viable alternative health care providers. According to Ms. Tippy, an impairment rating is a scientific evaluation, and chiropractors are qualified to perform this function for their patients. She urged the committee to pass HB 33.

George Wood, Executive Secretary of the Montana Self Insurers Association, stated he spoke in opposition to HB 33. He stated the question is not just whether chiropractors can rate impairment, but their concern goes farther. Mr. Wood gave a brief history of previous attempts by the Chiropractic Association to have their proposal accepted, but their efforts were unsuccessful. The question of whether "medical" is a generic term was discussed by Mr. Wood. In the act the definition of impairment is used as a medical term. There is another consideration in terms of compensation and that is the payment for loss of wage. Only one

portion of that has to do with the medical. Impairment is one of the conditions on which disability is rated. He reiterated that "medical" is a medical term in the sense that it is used by medical doctors. He also stated that the standard of proof in disputed cases in Montana is one of preponderance of medical evidence. That has always been taken to mean the preponderance of the doctor testifying. They are concerned that if "medical" is accepted as a generic term in one section, that "medical" will then be a generic term when it comes to the element of proof, which is an entirely different matter. He stated that if it is changed in one place, the system may be upset as far the adjudication of cases by making it go farther into the other sections of the act. He recommended that HB 33 do not pass.

Oliver Goe, Attorney, stated that he wished to follow up on Mr. Woods' comments which reflect concerns of the Montana Municipal Insurance Authority regarding HB 33. He pointed out that this bill is not about chiropractic care, whether it is less or more expensive, or more or less beneficial to the worker, and has nothing to do with whether a chiropractor can treat an individual who is injured on the job. He further stated there is nothing in this bill which will prohibit or allow chiropractors to testify concerning their care and treatment of injured workers. However, the Worker's Compensation Act was amended in 1987 and made it very clear that impairment ratings are medical determinations. He stated the chiropractor clearly plays a role in the system, but he feels there is a potential problem with having them do impairment ratings which have always been medical determinations. He stated the amendment appears to be appropriate, and if the committee feels it is appropriate for chiropractors to do impairment ratings, he would urge the passage of the amendment.

Questions From Committee Members:

Senator Himsl asked if special training was given to chiropractors to do evaluations to which Dr. Pardis stated the training would come mostly through postgraduate courses. He stated the doctors currently in the field would have to go back to school to become certified to do ratings. The majority of chiropractors would not want to do impairment ratings, but a certain percentage would.

Senator Himsl also asked that since the impairment ratings are done after the whole healing, do they first

determine the person is fully healed, and then rate his disability. Dr. Pardis answered in the affirmative and stated that they are required to notify insurers when the patient has reached maximum medical improvements. Dr. Pardis indicated they are qualified to pass that judgment.

Senator Rasmussen stated that the Florida study indicated costs are less when chiropractors do the work. He asked Mr. Wood if they are interested in lowering costs. Mr. Wood advised that they are interested in costs. However, he questions studies - where they come from and what background is used.

Senator Rasmussen asked if there were mandatory education requirements as far as re-licensing is concerned. Dr. Blom advised that 12 hours per year are required. He stated three yearly seminars are provided, and if chiropractors wish to do impairment rating, they must be certified by the Chiropractic Board of Examiners, which is appointed by the Governor.

Senator Norman asked who commissioned the Florida study. Dr. Blom informed that it was made at the request of the Foundation for Chiropractic Research and Education. Senator Norman and Dr. Blom discussed various situations involving costs. Dr. Norman suggested that since chiropractors do not hospitalize patients, the study is saying that less extensive treatment costs less. Senator Norman then asked Dr. Blom if the bill as now amended would permit a chiropractor to evaluate a patient who was not treated by a chiropractor. Dr. Blom stated that was not the case. Senator Norman presented some hypothetical situations and questioned whether a chiropractor would be able to evaluate those cases. Dr. Blom stated he would only rate what is contained in their scope of practice.

Senator Rasmussen asked if the Florida study would be comparing apples to apples, that is injuries that did not include surgery would be factored out. Ms. Tippy said that is her understanding. She stated that both the Florida study and a study by the Oregon Work-Comp commission showed the same kinds of results. Regarding the impairment situation of who can do what, she stated that under current law an obstetrician can rate for neurological impairment or any other kind, and that is probably no more proper than a chiropractor being able to rate a neurological or cardiac disease.

Senator Lynch asked if Montana is the only state that does not allow chiropractors to rate. The proponents

indicated that was correct, and there is evidently no great problem in other states.

In response to a query by Senator Norman, Dr. Hudson advised that in a case where the patient was a patient of a chiropractor and he was referred to a medical orthopedist for surgery, under current Work-Comp laws there can only be one treating physician. Dr. Hudson stated it is his understanding that the orthopedist would then be the treating physician and it would be within his realm to do the impairment evaluation.

Closing by Sponsor: Representative Pavlovich closed by stating that he would accept the amendments if the committee sees fit to include them. (Exhibit #4)

DISPOSITION OF HOUSE BILL 33

Discussion: Discussion was had concerning the terms "chiropractic physician" and "Doctor of Chiropractic". It was decided to retain the terminology in the current statute, "chiropractor".

Amendments and Votes: Senator Lynch moved that the AMENDMENTS BE ADOPTED. Senators in favor, 6; opposed,0.

Recommendation and Vote: Senator Lynch moved that HB 33 BE CONCURRED IN AS AMENDED. Senators in favor, 6; opposed 0.

HEARING ON HOUSE BILL 305

Presentation and Opening Statement by Sponsor:
Representative Angela Russell, House District 99, stated that HB 305 is an act requiring the appointment of a person knowledgeable about Indian culture and family matters to child protective teams and youth placement committees. She stated in the last session there was a similar bill adding a person knowledgeable about Indian culture and family matters to foster care review committee. This bill is similar but it adds such a person to child protective teams and youth placement committees. She stated that the Indian population in Montana is about 5%, and they have a large and growing school-age population of 7%. According to Rep. Russell, they are very concerned that Indians be involved in all planning for their children either in their homes or in foster care.

List of Testifying Proponents and What Group they Represent:

ROLL CALL

PUBLIC HEALTH COMMITTEE

51st LEGISLATIVE SESSION -- 1989 Date 3/1/89

NAME	PRESENT	ABSENT	EXCUSED
Sen. Tom Hager	X		
Sen. Tom Rasmussen	X		
Sen. Lynch	X		
Sen. Himsl	X		
Sen. Norman	X		
Sen. McLane	X		
Sen. Pipinich		X	

Each day attach to minutes.

SENATE STANDING COMMITTEE REPORT

March 2, 1989

MR. PRESIDENT:

We, your committee on Public Health, Welfare, and Safety, having had under consideration HB 53 (third reading copy -- blue), respectfully report that HB 53 be amended and as so amended be concurred in:

Sponsor: Pavolich (Lynch)

1. Title, line 7.
Following: "~~CHIROPRACTOR~~"
Strike: "DOCTOR OF CHIROPRACTIC"
Insert: "CHIROPRACTOR IF THE CLAIMANT'S TREATING PHYSICIAN IS A CHIROPRACTOR"

2. Page 2, line 19.
Following: "~~chiropractor~~"
Strike: "DOCTOR OF CHIROPRACTIC"
Insert: "chiropractor"

3. Page 3, lines 12 and 13.
Following: "~~physician~~"
Strike: "AN EVALUATOR of the party's choice"
Insert: "a medical doctor or from a chiropractor if the claimant's treating physician is a chiropractor"

4. Page 5, lines 1 through 4.
Following: "~~chiropractor~~" on line 1
Strike: remainder of line 1 through "he" line 4
Insert: "except if the claimant's treating physician is a chiropractor, the evaluator may be a chiropractor who is"

AND AS AMENDED BE CONCURRED IN

Signed: _____
Thomas C. Hager, Chairman

3:00 p.m.

SCR0053.ACP

SENATE STANDING COMMITTEE REPORT

March 2, 1989

MR. PRESIDENT:

We, your committee on Public Health, Welfare, and Safety, having had under consideration HB 305 (third reading copy -- blue), respectfully report that HB 305 be concurred in.

Sponsor: Russell (Yellowtail)

BE CONCURRED

Signed: _____

Thomas O. Hager, Chairman

3:11 pm

Chiropractic Versus Medical Care: A Cost Analysis of Disability and Treatment for Back-Related Workers' Compensation Cases

SENATE HEALTH & WELFARE
EXHIBIT NO. #1
DATE 3/1/89
BILL NO. HB 33

by

Steve Wolk, Ph.D.
Director of Research
The Foundation for Chiropractic Education and Research

September 1988

EXECUTIVE SUMMARY

Chiropractic and medical care were compared in regard to the cost of disability and treatment for back-related injuries and illnesses resulting from closed workers' compensation claims in Florida. Claims established during Florida's 1985-1986 fiscal year were tracked until April 30, 1987. The comparison covered the following variables: duration of disability; cost of indemnity payments for work days lost; cost of all physician services and physician prescribed procedures (e.g., occupational and physical therapy and x-ray examinations and interpretations); cost of hospital services and procedures, both in-patient and out-patient costs; drug and supply costs; transportation costs; and miscellaneous treatment costs.

Statistics were compiled by the Office of Medical Services, Florida Division of Workers' Compensation, at the request of the Foundation for Chiropractic Education and Research and covered two groups: 10,233

closed cases that excluded any patient who underwent surgery (claimant group A); and 10,652 closed cases that included patients who underwent surgery (claimant group B). Claimant group B, therefore, included the cases from group A as well as the 419 claimants who had surgery. Analyses were restricted to only those claimants who had a "Temporary Total Disability"--claimants who experienced an incapacitating injury but who recovered after a period of treatment and returned to work.

The major findings were as follows:

1. The duration of temporary total disability represented by the average length of the compensation period, and the indemnity payments for work days lost, were substantially less for claimants treated by chiropractors compared with those treated by medical doctors. In the group of claimants that excluded surgery patients, the period of disability was 48.7% shorter for chiropractic patients; for the claimant group that included patients who underwent surgery, the duration of disability was 51.3% shorter for chiropractic patients.

2. The average cost of chiropractic physician services and prescribed procedures was significantly less than the corresponding cost for medical doctors. In both claimant groups, the cost of chiropractors' services and prescribed procedures was over 50% less than that of medical doctors (55.3% less in claimant group A and 58.8% less in claimant group B).

3. Claimants treated by medical doctors were hospitalized at a much higher rate than claimants treated by chiropractors and incurred

significant additional costs due to hospitalization services. Only 20.3% of chiropractic patients in each claimant group were hospitalized; 51.3% of medical patients in claimant group A and 52.2% of medical patients in group B were hospitalized. The higher rate of hospitalization of medical patients, coupled with a higher average cost of hospitalization, resulted in a substantial impact on the overall cost of care attributable to medical doctors.

4. The estimated average total cost of care, computed across all the major categories of treatment cost, was substantially higher for medical patients compared with chiropractic patients: 83.8% higher in the claimant group that excluded surgery patients and 95.3% higher in the claimant group that included surgery patients. These statistics, representing the total treatment costs of managing a work-related back injury, more accurately reflect the cost-effectiveness of chiropractic care over standard medical care.

In summary, the findings confirm that chiropractic case management, compared with standard medical case management, minimizes the impact of work-related back injuries and illnesses on prolonged absence from work and excessive treatment costs. These findings, along with those of earlier investigations, have important implications for employees, employers, and insurance carriers who should acknowledge that chiropractic health care is efficacious and effective in treating back injuries in the workplace.

SENATE HEALTH & WELFARE
EXHIBIT NO. #3
DATE 3/1/89
BILL NO. HB 33

STATEMENT REGARDING HOUSE BILL 33

My name is Norman H. Grosfield, and I am an attorney in Helena, Montana. I do primarily workers' compensation work in my law practice; and I represent both claimants and defendants in relation to workers' compensation matters.

Because I am currently involved in a trial at the district court, I am unable to attend the hearing on House Bill 33. However, I wish to state it is my belief that the bill should be passed by the Senate and the Legislature.

For many years, chiropractors were allowed to give impairment ratings. Because of some recent legislation, a question was raised as to whether they could continue to give impairment ratings; and it was concluded that they could not.

It has been my practice in representing both claimants and insurance carriers that chiropractors who treat patients, and certainly have the legal right to treat patients, render appropriate impairment ratings based on the guides that have been adopted by the American Medical Association. In fact, it has been my experience that, due to the nature of chiropractic treatment, chiropractors are in a position to know their patients very well, to understand their physical conditions and limitations in relation to industrial injuries, and are in a position to render valid and bona fide impairment ratings.

Under the proposed bill, a treating chiropractor could render an impairment rating that would be subject to agreement between the claimant and the insurer. If an insurance carrier disagrees with the impairment rating granted by a chiropractor, there is an easy remedy whereby the Division of Workers' Compensation would designate, probably orthopedic surgeons, to evaluate the impairment rating given by the chiropractor. Thus, there is full protection for the insurance carrier that may disagree with the impairment rating.

I think it is essential that the Legislature fully recognize the importance of chiropractic service to injured workers. This can be enhanced by recognizing that a treating chiropractor should be allowed to render an impairment rating, based on guides adopted by the American Medical Association, and that such impairment rating should be considered, subject to the review by a panel of others, if questions are raised as to the correctness of the rating.

Finally, I would suggest that the bill will save insurance carriers funds, in that currently if a chiropractor is the treating physician, an insurance carrier needs to refer the claimant to another physician for an evaluation. This seems to be a needless step, and in nearly all cases, I would submit that little, if any, disagreement will be raised regarding the impairment rating listed by the chiropractor.

I appreciate the opportunity to submit this written testimony in regard to House Bill 33.

SENATE HEALTH & WELFARE
EXHIBIT NO. #2
DATE 3/1/89
BILL NO HB# 33

Amend HB 33, third reading bill

Page 5, line 1

Following: "~~physician~~"

Strike: "OR"

Insert: "except that if the claimant's treating physician is a chiropractic physician, the evaluator may be"

HB 33
3-1-89

Amendments to House Bill No. 33
Third Reading Copy

Requested by Senator Lynch
For the Senate Public Health, Welfare and Safety Committee

Prepared by Tom Gomez, Staff Researcher
March 1, 1989

1. Title, line 7.
Following: "~~CHIROPRACTOR~~"
Strike: "DOCTOR OF CHIROPRACTIC"
Insert: "CHIROPRACTOR IF THE CLAIMANT'S TREATING PHYSICIAN IS A CHIROPRACTOR"

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4. Page 5, lines 1 through 4.
Following: "~~physician~~" on line 1
Strike: remainder of line 1 through "be" line 4
Insert: "except if the claimant's treating physician is a chiropractor, the evaluator may be a chiropractor who is"

MINUTES

MONTANA HOUSE OF REPRESENTATIVES
51st LEGISLATURE - REGULAR SESSION

COMMITTEE ON HUMAN SERVICES AND AGING

Call to Order: By Chairman Stella Jean Hansen, on January 4, 1989, at 3:00 p.m.

ROLL CALL

Members Present: All

Members Excused: None

Members Absent: None

Staff Present: Mary McCue, Legislative Council

Announcements/Discussion: Rules of procedure for members of the committee. (Exhibit 1).

HEARING ON HOUSE BILL 33

Presentation and Opening Statement by Sponsor: Rep. Pavlovich, District 70, stated that this bill required a Workers' Compensation impairment evaluator to be a chiropractor if the claimant's treating physician is a chiropractor.

List of Testifying Proponents and What Group they Represent:

Michael Pardis, D.C.
Gary Blom, D.C.
Lou Sage, D.C.
Bonnie Tippy, Montana Chiropractor's Association

List of Testifying Opponents and What Group They Represent:

Jerome Loendorf, Montana Medical Association
John W. McMahon, M.D.
Hiram Shaw, Montana Department of Labor and Industry
Oliver Goe, Montana Municipal Insurance Association

Testimony:

Michael Pardis, D.C., indicated his support of this legislation and also said that chiropractors have

always been able to rate impairments for on-the-job workers up until two years ago and that is when the W.C. bill excluded them.

Gary Blom, D.C., stated that he was fully trained to rate impairments and had done this for many years until this privilege was taken from him. Dr. Blom said that it is demeaning to an injured worker not to be able to be rated by a chiropractor if this is the wish of the patient. He feels that it is unconstitutional for both the patient and chiropractor.

Lou Sage, D.C., stated that the State Board of Chiropractors lends its support to this bill. This bill would also extend the authority of the Board to make them responsible for setting up the guidelines for certification.

Bonnie Tippy supports this bill and distributed Exhibit 2.

Jerome Loendorf, an opponent to this legislation, said that no discredit is indicated in his testimony. The page 4 amendment was his concern. If a claimant chooses a chiropractor as his treating physician, the W.C. loses its right to whatever physician W.C. wants as its evaluator. (Exhibit 3).

John W. McMahon, M.D., opposing this bill, discussed specific patients with specific injuries and the ability of the W.C. to hire the best expertise it can to evaluate patients.

Hiram Shaw, in opposition, stated that the bill provided so many conflicts between the definitions of physicians and chiropractors that the basic definitions were amended in the 1987 session to clarify specifically who can do impairment evaluations and that it would be extremely detrimental to the ability of the W.C. to obtain appropriate impairment evaluations. (Exhibit 4).

Oliver Goe said the passage of the bill will not only affect the uniformity of the benefits which are to be provided to the workers but also will unnecessarily expand the persons under W.C. who would be qualified to render the ratings.

Questions From Committee Members: Rep. Whalen asked Oliver Goe if injured workers under W.C. have adopted the Montana Rules of Civil Procedure and the Montana Rules of Evidence. Mr. Goe indicated that they were

applicable. Rep. Whalen also asked Mr. Goe if a worker could receive an independent medical examination and Goe's response was a "yes" to this statement. Rep. Whalen then asked if this would not be evidenced in any disputed litigation and Goe responded "true". Again, Rep. Whalen asked whether chiropractors were competent to give evaluations and Mr. Goe indicated that he did not have the expertise to answer this question.

Rep. Simon asked Hiram Shaw what qualifications physicians have with regard to doing these kinds of evaluations and Mr. Shaw stated that physicians are solicited from the Board of Medical Examiners based on Board eligible certification. Rep. Simon asked if chiropractors were certified to be treating in a particular area and are they certified to be doing impairment ratings. Mr. Shaw said they would be considered certified in that area.

Rep. Blotkamp asked Gary Blom if it was for the good of the patient and to whether that patient is better off by receiving a chiropractors' evaluation or a doctor's evaluation, and Dr. Blom indicated "yes" to this question.

Rep. Good asked Hiram Shaw if there were two evaluations and a tiebreaker, would you object if any of those evaluations were a chiropractor and Mr. Shaw said that he would object.

Rep. Simon asked Michael Pardis if he were solely treating a patient what would the cost of that evaluation be and Dr. Pardis said $100.00. Rep. Simon then asked Dr. McMahon if a patient had been treated by a chiropractor solely and was then sent to you for an evaluation, what would it cost to take a patient that you had never seen. He said it would be a system evaluation which would be $40.00-$60.00, depending on what he did.

Rep. Boharski asked Rep. Pavlovich, who in turn referred the question to Dr. Blom, if a chiropractor is qualified to make a determination of an impairment based upon the whole person when that doctor is trained to deal specifically with injuries related to the spinal cord. Dr. Blom stated that if there were other systems involved, a chiropractic physician would be involved. Rep. Boharski then asked if a medical doctor could ask a medical doctor input while doing an evaluation and Mr. Shaw stated "no".

Closing by Sponsor: Rep. Pavlovich supplied a copy of the Supreme Court decision which is also supplied in

Exhibit 4 plus a Statement of Intent which is supplied as Exhibit 5.

DISPOSITION OF HB 33

Disposition of HB 33 is on hold.

Amendments and Votes: None

Recommendation and Vote: None

HEARING ON HOUSE BILL 37

Presentation and Opening Statement by Sponsor: Rep. Cohen stated that this bill was an act removing the requirement that the director of the Department of Health and Environmental Sciences be a physician.

List of Testifying Proponents and What Group they Represent:

Robert A. Ellerd, Governors Office
Robert R. Johnson, Montana Public Health Association
Rose Hughes, Montana Health Care Association
Kim Wilson, Montana Sierra Club
Mona Jamison, Rocky Mountain Treatment Center
George M. Fenner, RES Management Services
Meg Nelson, Montana Environmental Center

List of Testifying Opponents and What Group They Represent:

Jerome Loendorf, Montana Medical Association
John W. McMahon, M.D.
Barbara Booher, Montana Nurses Association

Testimony:

Robert A. Ellerd stated that the Governor felt that the director should be and may be a qualified administrator and still it does not exclude a doctor from serving if so chosen.

Robert R. Johnson, also the director of the City/County Health Department, supports this legislation. He said strong management and strong leadership is primary. The choosing of a strong leader by the Governor, who is not necessarily a doctor, would be the wish of this proponent. The leadership of the director should be more important than for that director to have an M.D. license. (Exhibit

within those limits. We find no abuse of discretion in the sentences imposed on the defendant.

The judgment of the district court is affirmed.

AFFIRMED.

228 Neb. 191

[1]Ronald Dean RODGERS, Appellee,

v.

Roger SPARKS, Doing Business as Sparks Concrete, and the Hartford Insurance Company, Third-Party Plaintiff, Appellants;

Cornhusker Casualty Company, Third-Party Defendant, Appellee.

No. 87-599.

Supreme Court of Nebraska.

April 8, 1988.

In workers' compensation proceeding, the Workers' Compensation Court awarded compensation for total temporary disability, loss of earning power, rehabilitation benefits, chiropractic expenses, and attorney's fee, and employer and its insurer appealed. The Supreme Court, held that: (1) duly licensed and practicing chiropractor is competent to testify as expert witness in workers' compensation case within scope of his knowledge according to his qualifications in field of chiropractic; (2) when record presents nothing more than conflicting medical testimony, appellate court will not substitute its judgment for that of workers' compensation court; and (3) finding with regard to causation of workers compensation injury will not be set aside unless clearly wrong.

Affirmed.

1. Workers' Compensation ⇐1417

In workers compensation cases, unless character of injury is objective such as where injury's nature and effect are plainly apparent, injury is subjective condition, requiring opinion by expert to establish causal relationship between incident and injury as well as any claimed disability consequent to such injury.

2. Workers' Compensation ⇐1417

A workers' compensation claimant must show by competent medical testimony causal connection between alleged injury, employment and disability.

3. Administrative Law and Procedure ⇐461, 792

Workers' Compensation ⇐1396, 1704

Duly licensed and practicing chiropractor is competent to testify as expert witness in workers' compensation hearing within scope of his knowledge according to his qualifications in field of chiropractic, and weight of his testimony is question for fact finder.

4. Workers' Compensation ⇐1396

Chiropractor who treated injured employee was properly permitted to testify in workers' compensation hearing that in his opinion, employee's injury was caused by lifting of heavy pipe and that second incident approximately one year later was exacerbation of original injury, and further, was properly permitted to testify regarding percentage of employee's disability.

5. Workers' Compensation ⇐1939.8

When record presents nothing more than conflicting medical testimony, appellate court will not substitute its judgment for that of workers' compensation court.

6. Workers' Compensation ⇐1939.11(1)

Finding with regard to causation of injury in workers' compensation case will not be set aside unless clearly wrong.

7. Workers' Compensation ⇐1624, 1634, 1637

Competent testimony supported award for temporary total disability, 20% loss of earning power and rehabilitation benefits to workers' compensation claimant despite

EXHIBIT 3A
DATE 1-11-89
HB 33

testimony by orthopedic surgeon that claimant had no disability; chiropractor who treated claimant after injury testified as to existence of disability.

Syllabus by the Court

1. **Workers' Compensation: Expert Witnesses.** Unless the character of an injury is objective, that is, an injury's nature and effect are plainly apparent, an injury is a subjective condition, requiring an opinion by an expert to establish the causal relationship between an incident and the injury as well as any claimed disability consequent to such injury.

2. **Workers' Compensation: Expert Witnesses.** The employee must show by competent medical testimony the causal connection between the alleged injury, the employment, and the disability.

3. **Workers' Compensation: Expert Witnesses.** A duly licensed and practicing chiropractor is competent to testify as an expert witness within the scope of his knowledge according to his qualifications in the field of chiropractic, and the weight of his testimony is a question for the fact finder.

4. **Workers' Compensation: Expert Witnesses: Appeal and Error.** When the record presents nothing more than conflicting medical testimony, this court will not substitute its judgment for that of the Workers' Compensation Court.

5. **Workers' Compensation: Appeal and Error.** A finding with regard to causation of an injury will not be set aside unless clearly wrong.

Francis L. Winner of Winner, Nichols, Douglas, Kelly and Arfmann, Scottsbluff, for third-party plaintiff, appellants.

Robert G. Pahlke of Van Steenberg, Brower, Chaloupka, Mullin & Holyoke, P.C., Scottsbluff, for appellee Ronald D. Rodgers.

Walter E. Zink II of Baylor, Evnen, Curtiss, Grimit & Witt, Lincoln, for third-party defendant, appellee Cornhusker Cas. Co.

[1]BOSLAUGH, CAPORALE, and GRANT, JJ., and RIST and CLARK, District Judges.

PER CURIAM.

This is an appeal in a proceeding under the Workers' Compensation Act. The plaintiff, Ronald Dean Rodgers, alleged that he was injured on July 25, 1983, while employed as a laborer by the defendant Roger Sparks, doing business as Sparks Concrete.

According to the plaintiff, he was injured while working at a feedlot, pouring a cement slab and putting up steel pipes. Rodgers testified he was attempting to hold up a steel pipe, which weighed approximately 200 pounds, when he developed a sharp stabbing pain in his chest and back and then collapsed and had trouble breathing. At his own request, he was taken to see Dr. Daryl Wills, a licensed chiropractor, that same day.

Dr. Wills' examination consisted of examining Rodgers' thoracic spine with palpation, motion palpation, and ranges of motion. Rodgers refused to have an x ray taken. Dr. Wills diagnosed the injury as an acute moderate to severe traumatic thoracic juxtaposition with associated myalgia, neuralgia, and deep and superficial muscle spasm. Dr. Wills testified that in layman's terms Rodgers had pulled the muscles in his back, which shifted vertebrae, and developed pain, nerve irritation, and muscle spasms. He further testified that this was a cartilaginous injury in which the heavy lifting depressed the shoulder girdle, which depressed the rib cage. The torquing of the ribs brought a strain on the cartilages. There are lightning joints between the cartilages and the sternum in the rib area, which are held by thin ligament structures both anteriorly and posteriorly. When an injury or trauma is experienced, those ligaments are stretched and/or torn.

Dr. Wills' treatment for this condition included therapy to the muscles, chiropractic manipulations, and pulse ultrasound therapy to the thoracic and external or

chest spine. Rodgers was also placed in a rib orthopedic appliance.

After the initial visit on the day of the injury, Dr. Wills treated Rodgers on July 27 and July 29, 1983, for aches, weakness, and pain. Rodgers returned on August 16 and 19 and [1]October 25, 1983. Rodgers continued to have problems relating to rib irritation and again sought treatment, on November 18, 1983. Rodgers continued to work after the accident until September 29, 1983, doing the same kind of work. He returned to work in April 1984, after the winter layoff, again doing the same type of work.

In June 1984, while still employed by Sparks, Rodgers was injured while pushing a wheelbarrow filled with cement, and which weighed about 300 pounds, through approximately 6 inches of sand. While pushing the wheelbarrow, he experienced a sharp stabbing pain and fell to the ground. In comparing this with the previous injury, Rodgers testified that it felt like the exact same pain. He visited Dr. Wills the next day, June 19, 1984. Dr. Wills diagnosed the injury as acute traumatic costovertebral and costosternal juxtaposition, with associated intercostal myalgia and neuralgia. As compared to the earlier injury, Dr. Wills testified that it involved the same area of the spine and that this diagnosis was consistent with the previous diagnosis.

Rodgers visited Dr. Wills again on June 21, 1984, and on May 13, 1985, he saw Dr. Wills, with complaints that he felt his ribs were out of place. Rodgers continued to visit, with complaints of chest pain, on May 20, June 1, August 5, September 10, and December 18, 1985. On December 18, 1985, x rays were taken for the first time. Dr. Wills testified that the x rays indicated that Rodgers had rotational problems of the vertebrae and a marked subluxation of one of his ribs. He explained that subluxation is an off-centering of the joint fixed within a range of motion so that it cannot move freely.

Dr. Wills again saw Rodgers for chest complaints on January 3, 1986; on February 4, for stiffness of the cervical spine; on February 19, for neck discomfort and chest pain; and on March 12, for cervical spine stiffness, headache, and chest trouble. He returned for similar problems on April 16, May 1, and August 14, 1986.

Rodgers testified that since the accident on July 25, 1983, he has had pain in his chest and rib area whenever he lifts something heavy.

On August 7, 1986, Rodgers filed a petition in the Workers' [2]Compensation Court, claiming that he was injured on July 25, 1983, while working for Sparks, who was at that time insured by The Hartford Insurance Company.

Hartford answered, denying liability, and alleging that Rodgers' injury took place on June 18, 1984, during a time when Cornhusker Casualty Company was the employer's insurance carrier.

After a hearing before a single judge, the compensation court found that the second injury on June 18, 1984, caused Rodgers' disability, and dismissed the petition as to Sparks and Hartford. The court also dismissed a third-party complaint against Cornhusker Casualty because the statute of limitations barred recovery for the accident of June 18, 1984.

On rehearing before a three-judge panel, the compensation court found that the accident on July 25, 1983, caused Rodgers' disability and that the second accident on June 18, 1984, only exacerbated the original injury. Two judges awarded compensation for temporary total disability, 20 percent loss of earning power, rehabilitation benefits, chiropractic expenses, and an attorney fee. The third member of the panel found that the plaintiff's loss of earning power did not exceed 5 percent and that rehabilitation benefits should be denied because the plaintiff could return to the work for which he had previous training or experience. The third-party complaint against Cornhusker Casualty was again dismissed.

Sparks and Hartford have appealed.

The appellants' principal assignment of error is that the compensation court erred in relying exclusively on the testimony of a

chiropractor to establish medical standards beyond the scope of chiropractic.

[1, 2] In workers' compensation cases,

> Unless the character of an injury is objective, that is, an injury's nature and effect are plainly apparent, an injury is a subjective condition, requiring an opinion by an expert to establish the causal relationship between an incident and the injury as well as any claimed disability consequent to such injury.

Mendoza v. Omaha Meat Processors, 225 Neb. 771, 785, 408 N.W.2d 280, 289 (1987). See, also, *Hamer v. Henry*, 215 Neb. 805, 341 N.W.2d 322 (1983); *Mack v. Dale Electronics, Inc.*, 209 Neb. 367, 307 N.W.2d 814 (1981).

> [W]here the claimed injuries are of such a character as to require skilled and professional persons to determine the cause and extent thereof, the question is one of science. Such a question must necessarily be determined from testimony of skilled professional persons and cannot be determined from the testimony of unskilled witnesses having no scientific knowledge of such injuries. The employee must show by competent medical testimony the causal connection between the alleged injury, the employment, and the disability.

Hamer v. Henry, supra 215 Neb. at 809, 341 N.W.2d at 325.

[3] The issue here is whether the testimony of a chiropractor was "competent medical testimony."

Under Neb.Rev.Stat. § 71-177 (Reissue 1986), the practice of chiropractic is defined as being one or a combination of the following, without the use of drugs or surgery:

> (1) The diagnosis and analysis of the living human body for the purpose of detecting ailments, disorders, and disease by the use of diagnostic X-ray of the axial skeleton excluding the skull, physical and clinical examination, and routine procedures including urine analysis; or (2) the science and art of treating human ailments, disorders, and disease by locating and removing any interference with the transmission and expression of nerve energy in the human body by chiropractic adjustment, chiropractic physiotherapy, and the use of exercise, nutrition, dietary guidance, and colonic irrigation.

Although it is clear that a chiropractor is not licensed to engage in the practice of medicine and surgery as defined under Neb.Rev.Stat. § 71-1, 104 (Reissue 1986), the practice of chiropractic is a skilled profession. Neb.Rev.Stat. § 71-179 (Reissue 1986) requires:

> Every applicant for a license to practice chiropractic shall (1) present satisfactory evidence that he has completed a four-year course in an accredited high school; (2) present proof of graduation from an accredited college of chiropractic; and (3) pass an examination prescribed by the Board of Examiners in Chiropractic in the subjects of anatomy, adjusting, bacteriology, chemistry, chiropractic physiotherapy, hygiene, pathology, roentgenology, orthopedics, physiology, symptomatology, palpation, principles and practice of chiropractic; *Provided*, that the Board of Examiners in Chiropractic may waive the written examination for an applicant who holds a National Board of Chiropractic Examiners Certificate who meets the requirements of this section and who satisfactorily passes all oral and practical examinations of the Board of Examiners in Chiropractic.

In *Chalupa v. Industrial Commission*, 109 Ariz. 340, 509 P.2d 610 (1973), the court considered the extent to which a licensed chiropractor could testify as an expert in an Industrial Commission hearing. The court granted review to correct an incorrect statement of law contained in the lower court's decision, which had stated in part that " 'while a chiropractor or naturopath may give testimony as to observable facts within his realm of knowledge and training, any other testimony he might offer which takes the form of medical conclusions (as to causation or disability, for example) cannot be regarded as expert medical testimony.' " 109 Ariz. at 341, 509 P.2d at 611.

The Arizona court noted that while chiropractors, unlike physicians, were not com-

petent to give expert testimony in the entire medical field, they were competent as expert witnesses in their limited field of practice. The court held that, regardless of chiropractors' limitations,

> [W]e do not believe that a statute which allows [a chiropractor] to manipulate or treat by hand articulations of the spinal column denies him the right to diagnose the reasons for that treatment. We believe that he is a competent witness to testify as to causation of any abnormalities of the spine.

109 Ariz. at 341–42, 509 P.2d at 611–12.

In *Fries v. Goldsby*, 163 Neb. 424, 435, 80 N.W.2d 171, 178 (1956), we said that "a duly licensed and practicing chiropractor is competent to testify as an expert witness within the scope of his knowledge according to his qualifications in the field of chiropractics, and the weight of his testimony is a question for [197] the jury." What must now be determined is whether causation and permanency are within the scope of the field of chiropractic.

Other courts appear to hold, generally, that chiropractors are competent to express an opinion as to the cause of an injury, its probable effects, and its permanency.

In *Miss. Farm Bureau Mut. Ins. Co. v. Garrett*, 487 So.2d 1320 (Miss.1986), the court held that one who is qualified as an expert in chiropractic may state an opinion regarding diagnosis, causation, and prognosis of an injury when the testimony is carefully limited to the field of chiropractic. "The fact that medical doctors ... might even be qualified to give better and more reliable opinions is beside the point." 487 So.2d at 1327. The court stated it is within the discretion of the trial court as to whether a chiropractor's testimony would be helpful.

In *Klingman v. Kruschke*, 115 Wis.2d 124, 339 N.W.2d 603 (1983), a chiropractor was allowed to give his opinion concerning the cause and permanence of the plaintiff's injuries in light of the fact that proper foundation was laid. The chiropractor based his opinion on his examination of the plaintiff and on statements made by the plaintiff during the examination that the neck stiffness had begun after the accident. The chiropractor diagnosed it as an injury to the cervical spine with associated nerve damage. The court held that the plaintiff's statements regarding neck stiffness provided sufficient foundation for the chiropractor's conclusion that the accident caused the injuries, and noted that it was for the jury to weigh the credibility.

In *Stevens v. Smallman*, 267 Ark. 786, 590 S.W.2d 674 (1979), the court held that a chiropractor could express his opinion as to whether the plaintiff was permanently disabled from an auto collision, where the chiropractor had examined the plaintiff, taken a history of his complaints, and treated him over a period of several months. The chiropractor was permitted to testify that the patient had muscle spasms in the cervical area, misalignment in the vertebral column, limitation of motion in the cervical area, and continuing pain, and that because the muscle spasms and pain had not cleared up during months of treatment, the patient had suffered a 5– to 7-percent permanent disability.

[198] In *Line v. Nouric*, 298 Minn. 269, 215 N.W.2d 52 (1974), the court allowed a chiropractor to testify that the plaintiff had suffered general spinal sprain and strain and that as a result, some of the muscles had lost their ability to hold the vertebrae in place and, further, that the cause of this condition was an automobile accident and that plaintiff had suffered a 15– to 20-percent permanent partial disability of the mid and upper thoracic spine. The court held it permissible for a chiropractor to render opinions based on reasonable chiropractic certainty as to the probable effects, permanency, and future medical requirements, where proper foundation for such opinion has been laid.

Finally, in *Badke v. Barnett*, 35 A.D.2d 347, 316 N.Y.S.2d 177 (1970), the court rejected an argument that chiropractors should not be permitted to give expert medical testimony on questions of diagnosis, prognosis, and causal connection because they lack the extensive training of a physician. The court held that because chiropractors are extensively trained in the

practice of chiropractic and are qualified to treat patients suffering from chiropractic ailments, a chiropractor should be deemed competent to testify as an expert witness and express his opinion as to the nature of a chiropractic ailment and its probable cause and duration. Hence, it was proper for the chiropractor to testify that, based on his examination of the plaintiff, she suffered from a subluxation, or a slight overriding of one vertebra against the other. This caused nerve roots in the vertebral openings to be pinched, which in turn caused muscle spasms. The chiropractor testified that it was his opinion that the auto accident was the cause and the injuries were permanent. The court rejected the argument that this testimony was beyond the scope of chiropractic and was entering the fields of neurology and orthopedics, because the chiropractor spoke of nerves and bone solely in the context of the subluxation he had detected in the plaintiff's spinal column.

[4] The witness in this case, Dr. Wills, was a qualified expert in chiropractic. He obtained his degree as a doctor of chiropractic in 1973 and has practiced in the profession ever since. During the course of his training he studied anatomy, physiology, microbiology, chemistry, bacteriology, and public health. The [199] doctor of chiropractic program consists of 2 years of preprofessional study and 5 years of professional study, including clinical work. He averages 50 hours per year of continuing education and is currently president of the Nebraska chiropractic association.

Being qualified as an expert, Dr. Wills was properly permitted to testify that, in his opinion, Rodgers' injury was caused by the lifting of a heavy pipe on July 25, 1983, and that the second incident on June 18, 1984, was an exacerbation of the original injury. He was properly permitted to testify regarding the percentage of Rodgers' disability. Sufficient foundation existed for his opinion regarding disability because of his repeated treatments of Rodgers over the years and because of his education in spinal impairment ratings.

The second and third assignments of error are that the court erred in making an award having no competent evidence to support it and erred in making an award for an injury where the only competent evidence showed a different and separate injury was responsible.

Dr. Bruce Claussen, an orthopedic surgeon, examined Rodgers on December 18, 1986, and found no abnormalities in the costosternal area where the breastbone meets the ribs. There were no abnormalities as to the cervical and thoracic spine, and Rodgers had an acceptable range of motion. Rodgers did have some tenderness in the front of the chest in the area where the breastbone meets the ribs, at about the third rib. Dr. Claussen referred Rodgers to a radiologist for x rays. X rays made of the area of the third rib indicated no abnormalities. Dr. Claussen testified that he could not explain the popping sound Rodgers complained of in his ribs, but stated it possibly could be due to the strain of the muscles and the ligaments. Dr. Claussen was of the opinion that the plaintiff had no disability as a result of either of the incidents, but on a "purely speculative basis" it was possible he might have an impairment of 2 to 3 percent or less.

Dr. Wills testified that the cause of Rodgers' first injury on July 25, 1983, was his lifting of the heavy pipe. In describing the relationship between this injury and the wheelbarrow incident on June 18, 1984, he testified that the pain Rodgers felt as he pushed the wheelbarrow was due to an exacerbation of his first [200] injury. He explained that the injury Rodgers sustained on July 25, 1983, involved a stretching or tearing of the ligaments, in which case there would be a deformation of the connective tissue, resulting in scar tissue which would not allow healing. The popping sound Rodgers reported hearing in his chest was due to joints that were torn loose and did not heal properly. He stated that Rodgers had never healed properly and when Rodgers returned for treatment in June 1984, he treated his condition as an exacerbation of the original injury.

He further testified that Rodgers' injury is a permanent condition with respect to Rodgers' experiencing pain upon heavy lifting, pushing, or pulling.

As to the extent of disability, Dr. Wills was of the opinion that Rodgers had a 15-percent disability as to his work capacity and a reduction of approximately 25 percent of his preinjury capacity for performing such functions as bending, stooping, lifting, pushing, pulling, climbing, or other comparable physical efforts. He explained that work disability does not correlate directly with impairment, in that a patient can have an impairment rating of a certain percentage and a disability rating of a different percentage based upon the type of work that the patient does.

[5] When the record presents nothing more than conflicting medical testimony, this court will not substitute its judgment for that of the Workers' Compensation Court. *Nice v. IBP, inc.*, 226 Neb. 538, 412 N.W.2d 477 (1987); *Ward v. City of Mitchell*, 224 Neb. 711, 400 N.W.2d 862 (1987).

[6] A finding with regard to causation of an injury will not be set aside unless clearly wrong. *Kingslan v. Jensen Tire Co.*, 227 Neb. 294, 417 N.W.2d 164 (1987). The findings of fact made by the Workers' Compensation Court after rehearing have the same effect as a jury verdict in a civil case and will not be set aside unless clearly wrong. *Kuticka v. University of Nebraska-Lincoln*, 227 Neb. 565, 418 N.W.2d 593 (1988).

[7] Since there was competent testimony to support the award for Rodgers, the judgment of the compensation court is affirmed.

The plaintiff is allowed $1,000 for the services of his attorney in this court.

AFFIRMED.

228 Neb. 201

[1,2] STATE of Nebraska, Appellee,

v.

Kim M. BRITT, Appellant.

No. 87-642.

Supreme Court of Nebraska.

April 8, 1988.

Defendant was convicted in the District Court, Douglas County, Donald J. Hamilton, J., of possession of heroin with intent to distribute, deliver, or dispense, and possession of marijuana with intent to distribute, deliver, or dispense, and he appealed. The Supreme Court, Grant, J., held that: (1) evidence was sufficient to support finding that defendant had physical or constructive possession of marijuana and heroin found in car and at residence with knowledge of its presence and its character as controlled substance, and thus supported finding of possession, and (2) circumstantial evidence was sufficient to support determination that marijuana and heroin were possessed by defendant with intent to distribute, deliver, or dispense.

Affirmed.

1. Drugs and Narcotics ⇐116

Evidence was sufficient to support finding that defendant had physical or constructive possession of marijuana and heroin found in car and at residence with knowledge of its presence and its character as controlled substance, and thus supported finding of possession; witness testified at trial that witness did not know that there were drugs in witness' vehicle until defendant tossed heroin at him, that black leather jacket in vehicle containing marijuana belonged to defendant, that witness had previously purchased marijuana from defendant at searched residence and that defendant had supplied marijuana from corn chip cannister in which police found marijuana.

HB 33
Comments by Division of Workers' Compensation
January 4, 1989

The proposed revision to section 39-71-711 (4), MCA, would, if enacted, be in conflict with the provisions of certain sections of Title 39 (Workers' Compensation) and Title 37 (Professions and Occupations). Also, the language of the revision itself is confusing. First, the term "chiropractic physician" is contradictory, in that a chiropractor is not a physician within the meaning of the laws of the State of Montana (see below). (The language could be clarified by replacing the terms "treating physician" and "chiropractic physician" with the terms "treating chiropractor" and "chiropractic practitioner", respectively.) Second, the revision is ambiguous with respect to a requirement for chiropractors to act as second or third evaluators in the impairment evaluation dispute process. If the claimant's treating provider is a chiropractor, the proposed amendment to 39-71-711 (4) conflicts with 39-71-711 (2), "A claimant . . . may obtain an impairment rating from a physician of the party's choice . . .".

The following specific instances of conflict with existing statute are noted:

(1) Section 39-71-711 (1)(a) declares that an impairment rating "is a purely medical determination:; however, section 37-12-102 states that the practice of chiropractic is "declared not to be the practice of medicine or surgery within the meaning of the laws of the state of Montana defining the same." The revision would allow a chiropractor (who is not recognized as a practicer of medicine) to be an impairment evaluator (who must deliver an impairment rating by purely medical determination).

(2) Section 39-71-711 (1)(b) states that the impairment rating determined by an impairment evaluator "must be based on the current edition of the Guides to the Evaluation of Permanent Impairment published by the American Medical Association." The Glossary contained in this publication defines evaluation or rating of impairment as "an assessment of data collected during a clinical evaluation . . .", and further defines clinical evaluation as "the collection of data by a physician . . .". That is, impairment evaluation requires the assessment of data collected by a physician. HOwever, section 37-12-104 declares that while chiropractors may

EXHIBIT 4
DATE 1-4-89
HB 33

use the prefix "Doctor" as a title, they "shall not in any way imply that they are regular physicians or surgeons.: The revision would allow a chiropractor (who is not recognized as a physician) to perform an impairment evaluation (which requires clinical evaluation by a physician).

(3) More generally, the revision might be seen to expand chiropractors' scope of practice by allowing them to act as impairment evaluators -a function currently reserved for licensed physicians. This expansion conflicts with Title 37, Chapter 3.

The proposed revision to section 37-12-201, MCA, would present the same problems as those outlined for the revision to 39-71-711 (4).

5890E

VISITORS' REGISTER

HUMAN SERVICES AND AGING COMMITTEE

BILL NO. HB 33 DATE January 4, 1989

SPONSOR Representative Pavlovich

NAME (please print)	RESIDENCE	SUPPORT	OPPOSE
Oliver Cox - MMIA	29 N Last Chance Gulch		✓
Bonnie Tippy - MCA	350 N Last Chance Gulch	✓	
Margaret Richardson MCA	350 N Last Chance Gulch	✓	
Jerome Loendorf	Helena, Mt.		✓
Gary Blom	Helena MT	✓	
[illegible]	Helena MT		✓
[illegible]	Helena, MT	✓	
Lou Hagle, D.C.	Ulcer MT	✓	
Hiram Shaw	Labor & Industry		✓
Steven Stanford	Labor & Industry		✓
Tohn A. Stiles	Helena MT		X
John Lawton	Billings		X
Carrie L. Barber	E. Helena / MSU		X

IF YOU CARE TO WRITE COMMENTS, ASK SECRETARY FOR WITNESS STATEMENT FORM.

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

PROPOSED STATEMENT OF INTENT

HB 33

This bill authorizes the Board of Chiropractors to adopt a rule for the certification of impairment evaluators within their profession. The Board should consider the applicant's experience in treating industrial accidents and any academic training he may have in using the impairment rating guides recognized by the division of worker's compensation.

EXHIBIT 5
DATE 1-4-89
HB 33

None

Testimony:

John Madsen supplied Exhibit 2 and stated that he was a proponent to this bill. His department often times has information which would be of value to probation officers and their eventual treatment of the youth. The only way this information may be disclosed now is through a court order. Important information they may need is that the child was a victim of child abuse and that would have an impact on the treatment and disposition that the youth may need.

Mona Jamison supports this bill and stated that the probation officer has a key role in recommending to the court or else in terms of the youth placement committee what is the best placement of the child. To not have the availability of the records at placement time could be detrimental to the child.

Questions From Committee Members: None

Closing by Sponsor: Rep. Strizich closes.

DISPOSITION OF HB 80

Motion: A Motion was made by Rep. Strizich and seconded by Rep. Russell to DO PASS.

Discussion: None

Amendments and Votes: None

Recommendation and Vote: A vote was taken and all voted in favor.

DISPOSITION OF HB 33

Motion: A Motion was made by Rep. Whalen and seconded by Rep. Good that the amendments DO PASS.

Discussion: Rep. Whalen discussed the new amendments.

Amendments and Votes: A Substitute Motion was then made to take this bill from Table by Rep. Whalen and seconded by Rep. Good. Unanimously passed.

Motion: Rep. Whalen then made a Motion to DO PASS as Amended. Rep. Good seconded the Motion.

Amendments and Votes: The bill has been moved and seconded to DO PASS AS AMENDED.

Recommendation and Vote: Unanimous DO PASS as AMENDED.

ADJOURNMENT

Adjournment At: 3:30 p.m.

STELLA JEAN HANSEN, Chairman

SJH/ajs
0707.min

DAILY ROLL CALL

HUMAN SERVICES AND AGING COMMITTEE

51st LEGISLATIVE SESSION -- 1989

Date January 9, 1989

NAME	PRESENT	ABSENT	EXCUSED
Stella Jean Hansen	✓		
Bill Strizich	✓		
Robert Blotkamp	✓		
Jan Brown	✓		
Lloyd McCormick	✓		
Angela Russell	✓		
Carolyn Squires	✓		
Jessica Stickney	✓		
Timothy Whalen	✓		
William Boharski	✓		
Susan Good	✓		
Budd Gould	✓		
Roger Knapp	✓		
Thomas Lee	✓		
Thomas Nelson	✓		
Bruce Simon	✓		

CS-30

STANDING COMMITTEE REPORT

January 9, 1985
Page 1 of 2

Mr. Speaker: We, the committee on Human Services and Aging report that HOUSE BILL 33 (first reading copy -- white) do pass as amended.

Signed: _____
Stella Jean Hansen, Chairman

And, that such amendments to HOUSE BILL 33 read as follows:

1. Title, line 4.
Strike: "REQUIRING"
Insert: "ALLOWING"

2. Title, lines 5 and 6.
Strike: "CHIROPRACTOR IF THE CLAIMANT'S TREATING PHYSICIAN IS A CHIROPRACTOR"
Insert: "DOCTOR OF CHIROPRACTIC"

3. Page 2, line 18.
Strike: "chiropractor"
Insert: "doctor of chiropractic"

4. Page 3, line 11.
Strike: "a physician"
Insert: "an evaluator"

5. Page 4, lines 22 through 24.
Strike: "except that if the claimant's treating physician is a chiropractic physician, the evaluator must be a chiropractic physician"
Insert: "or a doctor of chiropractic"

6. Page 4, line 25.
Following: "chapter 12"
Strike: ", and"
Insert: ". If the evaluator is a doctor of chiropractic, he"

7. Page 5, line 1.
Strike: "that"
Following: "chapter"
Insert: "12"